# *IN THE SHADOW OF MEN:*
## *REPRODUCTIVE DECISION-MAKING AND WOMEN'S PSYCHOLOGICAL WELL-BEING IN INDONESIA*

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# I. INTRODUCTION

## A. Family Planning and the Position of Women

The family planning program in Indonesia, internationally recognized as one of the most impressive attempts to control fertility and population growth in the world, has contributed to a reduction in the total fertility rate from 5.6 in 1960s to 2.8 in 1994 (World Bank, 1990; UNFPA, 1990; CBS, 1995). At present, 55 percent of currently married women use contraception (CBS, 1995).

The family planning program is targeted primarily at women, and some argue that the low quality of care in the program reflects general attitudes toward women in Indonesian society (Hafidz et al., 1991; Smyth, 1990). Mboi (1994), for example, observed that some health professionals in Indonesia tend to belittle health complaints by women. A recent survey by the Indonesian Planned Parenthood Association (Subroto et al., 1995) found a lack of attention to women's reproductive rights during service delivery. For example, clients were frequently denied the opportunity to select the contraceptive methods which best suited their needs or preferences.

It is acknowledged that at present, the national family planning program has not been able to fulfill all aspects of women's needs. Part of the reason may be due to the ambiguity of the population policy in Indonesia. Wilopo (1995) argued that the Indonesian family planning program should be perceived as "beyond" family planning since it stresses the importance of building family resilience and family well-being over the timing and spacing of children. The policy is reflected through the enactment of the Law No. 10/1992 on Population, Development, and Development of Happy and Prosperous Families, and it is further stipulated in the Government Regulation No. 21/1994. According to those documents, the family should act in unity when planning and making decisions on timing and spacing of children.

In the extreme case of reproductive control (i.e. termination of pregnancy), a woman may have to face the public or the state and may be subject to a criminal lawsuit if she has an abortion (Petchesky, 1990; David, 1994). Indonesia recognizes the need for medically supervised termination of pregnancy for health and medical reasons but has been very reluctant to put it into the legal framework (Djohan et al., 1993; Widyantoro et al., 1990). In any case, only married women are legally permitted to undergo an abortion. Hence, many women seek help from illegal practitioners (Affandi, 1992).

## B. Decision-making and Women's Psychological Well-being

Studies conducted with minority families in the United States have indicated that women in marital relationships in which husbands are the dominant partners have poorer physical health, lower self-esteem, less autonomy, and poorer marital adjustment than women in more egalitarian relationships (Avis, 1985). Part of the reason for this is that in such marital relationships, women

usually give up more than men in terms of autonomy, career, friends, residence, and names (McGoldrick, 1989). They may also have to give up their reproductive rights.

Self-esteem, the extent to which one values oneself or how one feel about oneself, and the quality of marital relationships (adjustment) are core components of the psychological well-being of women. McGoldrick (1989) argues that self in relation to others, in contrast to independence and autonomy, has been the central theme of women's psychological development and identity formation, a fact that is often neglected by male psychologists. A recent attempt to operationalize empowerment (Shields, 1995) also indicates that when women feel that their selves are being valued, they feel a sense of worth which in turn affects their relationships in a manner conducive to maintaining more control and paying attention to their own needs over those of others. The relationship context is important since it provides the context in which nurturing takes place. Participants in Shields' study believed that the ability to put priority on their own needs sensitized them to the needs of others. Ability to nurture others is part of women's identity and a crucial component of their life satisfaction (McGoldrick, 1989; Miller, 1976).

**C. Cultural and Contextual Variables Affecting Decision-making**

The importance of recognizing women's sexual and reproductive rights, which are the rights to decide the spacing and timing of children and to attain the highest standard of sexual and reproductive health, was stressed in the International Conference on Population and Development (ICPD) in Cairo (Ashford, 1995; Wilopo, 1994). In his press conference upon returning from the ICPD, the Minister of Population Affairs and Family Planning, Dr. Haryono Suyono, indicated that Indonesia had ratified the ICPD *Platform of Action*. The Minister, however, also cautioned Indonesian policymakers that family planning policy should be implemented in accordance with local cultural and religious beliefs.

Reproductive control has been viewed as a means of empowering women. It may emancipate women from their traditional roles and enable them to pursue other activities. Tension between meeting women's individual reproductive rights and the need to let couples or families decide the timing, spacing and number of children is apparent in Indonesia. It is argued that when decisions in the family are made by couples or families who do not enjoy a relationship of balanced power, it is likely that the Indonesian woman will be in the disadvantaged position (cf. Subroto et al., 19995; Sadli, 1995b; Amaro, 1993). Husbands and significant others impose strong influences upon women's decisions to use and not use contraception (Subroto et al., 1994; Wolf, 1992). In Indonesia, opposition by husbands is the biggest factor preventing currently-married women from using contraception (CBS, 1995). A study by Wolf (1992) in Central Java indicated that women who live away from their own families and in-laws have greater power to negotiate family planning. In a study in Jakarta involving 51 wives of truck drivers and construction workers (who commonly have multiple sexual partners), Setiadi, Jatiputra and Santoso (ND) found that most of the women said they had difficulty talking with their husbands about daily and sexual matters. A program whose objective is to empower women to make their own

reproductive decisions must address the negotiating processes between women and their significant others.

Decision-making in the family, especially in a marital relationship, will be affected by the conjugal values and norms which govern the relationships. Few studies, however, have examined the decision-making processes regarding childbearing and the number of children in Indonesia. A study by Sayogyo in a village in Java found that women play the primary role in the decision-making process. Childrearing decisions were generally made jointly or though compromise between the spouses in (Berninghausen & Kerstan, 1992). Other institutions which may influence decision-making are traditional organizations such as savings and loan societies (*simpan pinjam*), rotating credit associations (*arisan*), prayer groups (*pengajian*), local religious leaders, and traditional midwives *(dukun bayi*) (Ancok, 1991).

**D. Study Objectives**

This study seeks to understand the processes involved when women make decisions regarding reproductive behavior and how the decisions made or the decision-making processes affect women's self-image and their relationships with significant others--spouse, children (in case of both wanted and unwanted pregnancy) and members of the extended family. The impact on self-image is an important concern since empowerment of women occurs when they have a more positive self-image (Hong & Seltzer, 1994; Petchesky, 1990; Worell & Remer, 1992). Figure 1 depicts the conceptual framework that served as a guide for this study.

The objectives of the study were to gain an understanding of the effects of the family planning program on the well-being of women, the decisions women make to exercise their reproductive rights, and the effects those decisions have on women's psychological well-being. The following questions were addressed in this study:

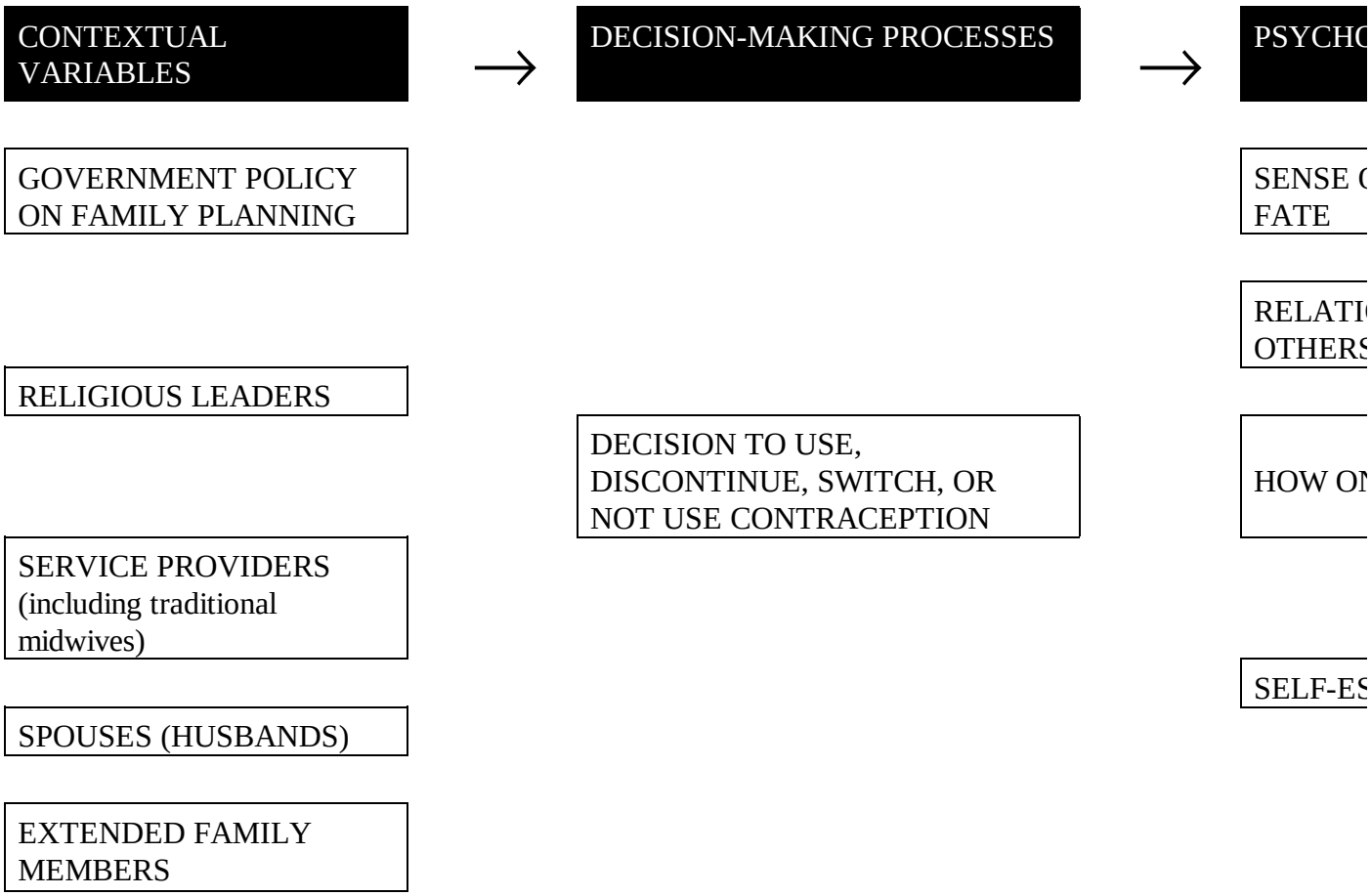
1. Who is involved in a woman's decision to start or stop using contraception or to switch method and how does a woman consider her own position in relation to others in the family planning decision-making process?

2. What does a woman do when her own ideas regarding family planning differ from those of others and how does this affect her self-image and image of others?

3. How does the use or non-use of family planning affect women's psychological well-being? What other factors affect women's psychological well-being?

4. What type of support do women receive from the family planning program regarding reproductive decision-making and what does she need to be provided in a family planning center to help her cope with any problems resulting from her reproductive control?

**Figure 1. Conceptual Model**



## II. METHODOLOGY

This study is part of a collection of four studies supported by the Women's Studies Project (WSP) in Indonesia. Each of the studies focuses on a different aspect of the WSP conceptual framework (Hardee et al., 1996) . Each study takes as its starting point contraceptive use or non-use (or, in the case of this study, reproductive decision-making) and looks at other aspects of women's lives that are affected by use of family planning. Broad dimensions of women's lives being studied in these four sub-projects include psychological well-being, women's roles in the family and their roles in the community. These three dimensions correspond to the WSP Conceptual Framework. The study populations identified in these four studies come primarily from the USAID-funded Service Delivery Expansion of Services (SDES) Project. In addition, Lampung and Palembang (South Sumatra) are included as part of the study population in one of the studies. There is no overlap of study populations, although by design, there is some overlap -- in addition to complementarity -- of study topics.

### A. Selection of Study Locations

This study was conducted in the provinces of Lampung and South Sumatra. Within Lampung and South Sumatra, specific locations were selected in consultation with the local Bureau of Statistics and National Family Planning Coodinating Board (BKKBN) offices. The study locations were also discussed with colleagues at the Universitas Sriwijaya in Palembang and Universitas Lampung at Bandar Lampung.

Selection criteria required that the selected study sites reflect the demographic and family planning program characteristics (high or low performance) of the respective provinces. Study sites in both provinces were also chosen because they offered the opportunity to gather information from established traditional and from transmigrant (internal migration) communities, and from both urban and rural areas.

#### 1. South Sumatra

South Sumatra is one of the largest and most densely populated provinces on the island of Sumatra. According to the latest population registration (BPS, 1995a) the province is presently home to 6,661,627 residents. The rate of population growth in South Sumatra has increased considerably from 2.2 percent in 1961-71 to 3.3 percent in 1971-80. Since then the rate has remained high -- 3.2 percent in 1980-90 and 3.3 percent in the last four years. The growth rate in South Sumatra is more than twice as high as the national rate of 1.6 percent (BPS, 1995b).

##### a. Urban Sites: Palembang Municipality

Based on the criteria noted above, Duku and Seberang Ulu I subdistricts were originally selected as urban study sites, as they are culturally diverse and the residents there are involved socially and economically in the urban life of the city of Palembang (South Sumatra's capital city). Seberang

Ulu I has a low family planning performance. After the study began, Seberang Ulu I was discovered to be a crime-ridden area in which it was unsafe to carry out the data collection. By the time this was discovered, however, it was too late to choose another research site. Therefore, the data collection for urban South Sumatra was conducted solely in Duku.

**b. Rural Sites: Lahat District**

In Lahat distict, an area six hour drive from Palembang, two villages were selected for the study: Tanjung Beringin and Perangai. Tanjung Beringin has a strong record in family planning participation. Tanjung Beringin's population is somewhat homogeneous, but less so than other villages in Lahat. Some of the inhabitants are descendants of Javanese migrants who came to the village during colonial times as plantation workers. Perangai is populated almost completely by indigenous Pasemah, or Lahat, people, and has lower participation in family planning.

**2. Lampung**

Lampung Province is located on Sunda Strait, on the southern tip of the island of Sumatra. It is the closest point on Sumatra to Indonesia's capital city of Jakarta (45 minutes by air or fourhours by bus and ferry). In the colonial period, Lampung was the largest rubber and coffee producer outside of Java. Most of the workers in that period were transported from villages in Java to work on the plantations by the British and Dutch Colonial Governments. In 1995, only one-fifth of Lampung's 6,448,251 inhabitants were indigenous Lampungese (BPS, 1995c). The population growth rate in Lampung has decreased from 3.3 percent in 1976 to 2.0 percent in 1994.

**a. Urban Sites: Lampung Municipality (Bandar Lampung)**

Two subdistricts in Bandar Lampung were selected to represent the urban communities in Lampung. Tanjung Karang Pusat has an ethnically heterogeneous population and a low performance in family planning participation. Pantai Panjang is a coastal area with a heterogeneous population (many migrants from Java and other parts of Indonesia, mostly South Sulawesi) and has a more successful record in family planning participation.

**b. Rural Sites: Lampung Tengah (Central Lampung)**

Rural areas were represented by two villages in the Lampung Tengah District. Gunung Sugih (which is also a subdistrict) has a homogenous population of indigenous Lampungese and a relatively poor record in family planning participation. Bandar Jaya is home to relatively newer migrants from Java and has maintained a sucessful family planning record. Bandar Jaya represents a more progressive village, as most of its residents are merchants who sell largely agricultural products. Lampung Tengah District is two hours from Bandar Lampung by car. Gunung Sugih is remote and difficult to reach due to its location on a hill without a good asphalt road. The road to Bandar Jaya is good, and there is plenty of public transportion to the village.
The selection of research sites for this study affected the budget considerably. The study was

originally budgeted to be conducted in Bali, which would have been less expensive. Some changes in the design of the study were necessary to compensate for the increased costs. For example, in-depth interviews with male participants could not be conducted.

**Table 1: Demographic Indicators, South Sumatra and Lampung Provinces.**

| Variables | South Sumatra | | Lampung | |
|---|---|---|---|---|
| | **Palembang (urban)** | **Lahat (rural)** | **Bandar Lampung (urban)** | **Central Lampung (rural)** |
| Population | 1,275,69 (1994) | 633,626 (1994) | 836,506 (1996) | 2,021,340 (1996) |
| Pop. growth rate | 2.70 (1990-94) | 1.40 (1990-94) | 1.65 (1990-95) | 1.08 (1990-95) |
| Sex ratio | 99 (1990-94) | 97 (1990-94) | 95 (1990-95) | 102 (1990-95) |
| Infant mortality rate | 55 (1990) | 82 (1990) | 26 (1995) | 56 (1995) |
| Total fertility rate | 2.43 (1990) | 3.32 (1990) | 3.12 (1996) | 2.98 (1996) |
| Labor force participation of women (in percent) | 35.8 (1994) | 47.5 (1994) | 45.73 (1996) | 60.26 (1996) |
| Percent women of reproductive age | 55.48 (1994) | 49.16 (1994) | 52.08 (1996) | 59.56 (1996) |

Sources: BPS (1994). *Indikator Sosial Sumatera Selatan*
BPS (1995). *Jumlah Penduduk Propinsi Sumatera Selatan*.
BPS (1996). *Profil Kesehatan Propinsi Lampung 1996*
BPS (1996). *Survey Sosial Ekonomi Nasional 1996 Propinsi Lampung*.

## B. Data Collection Methods

Three data collection methods were used in this study: focus group discussions (FGDs), a survey, and in-depth interviews. Since there has been virtually no research in the area of psychological well-being in relation to family planning in Indonesia, it was first necessary to understand women's experiences in their day-to-day lives in order to construct the survey instrument, particularly regarding psychological well-being. For that purpose, a series of FGDs was conducted with women and men in South Sumatra and Lampung. The survey of women was conducted to collect quantitative information on family planning practices and reproductive decision-making and their effects on women's psychological well-being among a large sample of women. Finally, in-depth interviews were conducted with women to elaborate on and complement the findings of the survey.

## C. Sampling Procedures

To be included in this study, women had to be of reproductive age (15-49), be currently or previously married, have at least one child, and not be officials of the BKKBN.

### 1. Focus Group Discussions with Women and Men

FGD participants were recruited by the field coordinator, with assistance from local leaders and staff of the village authority (*Kelurahan)*. To minimize the social desirability of results, the local coordinators were encouraged to recruit participants who were not recommended by government officers. A total of 78 women participated eight FGDs, and 38 men participated in four FGDs. The men were mostly spouses of the women who had been selected for the survey sample.

### 2. Survey of Women

A total of 800 women (400 in each province and 200 in each district) were included in the survey. Respondents for the survey were recruited differently in different locations. In Lampung province (Bandar Lampung and Lampung Tengah), two *Rukun Warga* (neighborhood groups) in each subdistrict were randomly selected, followed by the selection of the respective *Rukun Tetangga* (neighborhood communities). Respondents were also selected randomly from the head-of-household list provided by the BKKBN cadre. Only one woman per household was recruited.

The selection of respondents in South Sumatra was not random. When data collection started at the Duku subdistrict, the new head-of-household list (*Daftar Kepala Keluarga*) was not available. The existing list was not valid due to extensive migration. Therefore the survey was conducted by selecting the *Rukun Tetangga* randomly. Then, interviewers went door to door within the selected *Rukun Tetangga* seeking women who met the study criteria.

In Lahat district of South Sumatra, 294 households in Perangai and 137 in Tanjung Beringin were selected. The local authority provided lists of family planning acceptors -- a total of 96 women in Tanjung Beringin and 28 in Perangai. No head-of-household lists were available for recruitment. Since the number of households was small, most of the women in the reproductive ages and meeting the criteria for the study were recruited. Through door-to-door recruitment, the data collectors were able to obtain the expected number for the sample.

### 3. In-depth Interviews with Women

Participants for the in-depth interviews were selected from the survey respondents, after data collection for the survey was completed. Participants for the in-depth interviews were selected on the basis of urban-rural distribution, possible willingness to cooperate, and some samples of husband's participation. Although we planned to interview women and their spouses, budgetary limitation forced us to restrict the in-depth interviews to women. A total of 24 women, divided

equally among the four locations, were recruited according to the general criteria already explained for the survey. The in-depth interviews were conducted before the survey data were analyzed.

## D. Field Work

### 1. Focus Group Discussions

Focus group guidelines were developed by the study investigators, in collaboration with FHI. A total of 12 FGDs was conducted --three in each study site, two with women and one with men (Table 2).

**Table 2: Focus Group Discussions, South Sumatra and Lampung, 1996.**

| Sex of participants | Number of focus groups (number of participants per group) | | | |
|---|---|---|---|---|
| | **Palembang** | **Lahat** | **Bandar Lampung** | **Lampung Tengah** |
| Women | 2 (9,10) | 2 (10,11) | 2 (9,8) | 2 (8,8) |
| Men | 1 (8) | 1 (12) | 1(8) | 1 (10) |

Three small practice FGDs involving at least five participants in each group were conducted at Atma Jaya University and the University of Indonesia. Insights from these practice FGDs were used in the training of FGD leaders in Palembang and Lampung.

In June 1996, FGD training was conducted in South Sumatra and Lampung. The training sessions, conducted by the principal investigator and co-principal investigator, were attended by 10 field researchers in each region (including the local field coordinators). Topics covered in the training included: 1) the conceptual framework from the research proposal; 2) qualitative research methodology; 3) gender perspectives in qualitative research; 4) FGD techniques;
5) family planning and reproductive decision-making; 6) psychological well-being in colloquial language.

Each training session included conducting a practice FGD with groups of women and men in each location. Participants in those practice FGDs were recruited by the study coordinators, with the assistance of local leaders.

All discussions were transcribed verbatim and analyzed by the principal investigator and the co-principal investigator. No text analysis software was used in the analysis. Statements representing the common experience of the informants were identified and categorized thematically.

### 2. Survey of Women

**a. The Questionnaire**

The questionnaire for the survey was drafted in collaboration with FHI (see appendix 1). The draft was pretested with three women in Jakarta and was also sent to the field coordinators in Palembang and Lampung for pretesting.

**b. Interviewer Training**

Training for interviewers (all female) was conducted by the co-principal investigator on September 27-29 in Palembang and October 10-13, 1996, in Bandar Lampung. Ten interviewers in Palembang and twelve in Bandar Lampung participated in the training. In addition to the female interviewers, the local coordinators also employed male colleagues to help build rapport with the local leaders and assist with logistics during the study.

The training included: 1) a refresher on the design and methodology of the study; 2) an explanation with examples of each part of the questionnaire; 3) practice survey interviews among participants followed by reflection on the exercise; 4) discussion on how to handle problems during interviews; and 5) a presentation by a medical doctor on family planning methods (how each method works, side-effects, follow-up, and medical examinations), followed by discussion. The training also included a second pilot survey in the respective locations, after which the co-principal investigator assisted with final refinement of the questionnaire.

**c. Administration of the Survey Questionnaire**

Data collection in the urban areas of Palembang and Bandar Lampung immediately followed the training. Data collection in the rural areas was conducted later. Each interviewer was instructed to follow standard procedures in the administration of the questionnaire. Consent for the interviews was obtained from each respondent, and the confidentiality of their responses was explained. The interviews took an average of 45 minutes. Quality checks were performed by the local coordinators immediately after the data collection to ensure that missing information could be completed by the interviewers as soon as possible.

**3. In-depth Interviews**

**a. Training of Interviewers**

The principal investigator trained interviewers prior to the in-depth interviews. All interviewers from each province participated in the training. The two-day training stressed that because reproductive decision-making and psychological well-being are complex issues, the in-depth interviews should be conducted with patience and encouragement. Good listening skills and probing were practiced with peers and then with participants. The principal investigator assisted the interviewers with three in-depth interviews as an unobtrusive observer. At the end of those

initial interviews, a review meeting was conducted. The remaining interviews were assisted by the field coordinator.

### b. Implementation of Interviews

The in-depth interviews were conducted at the homes of the participants, using an interview guide developed by the study team in collaboration with FHI. Contacts were made by telephone (in the cities) or by visiting the residence to set up the interviews. The possible length of the interviews (two to three hours) was explained to prospective participants, and they were asked to propose the most convenient time for the interview. When possible, the in-depth interviews were conducted in private with the women. However, in some cases, others were present, particularly children and other female members of the family. The presence of these other people may have affected the results of the interview, but it was unavoidable. The field coordinator played an important role by talking to other household members or the head of the village while the interview was taking place to ensure that they would not disturb the interview.

## III. RESULTS

### A. Focus Group Discussions

The FGDs were designed to explore both positive and negative effects of participation and non-participation in the family planning program on women's lives. The following were the leading questions in the FGDs:

1. What are the reasons that you do or do not use family planning?
2. How is contraceptive use negotiated in your family, and who is considered the most influential in contraceptive decision-making?
3. What are examples of your positive/negative experiences (physical as well as psychological) using contraceptives?

In the in-depth interview quotes in the following sections, the respondent's sex can be identified by the code following a quote. The code for female respondents ends in W1 or W2, and the code for males ends in M.

#### 1. Socioeconomic Background and Cultural Values

It was widely acknowledged by participants in the FGDs that their family planning practice was affected by economic and cultural considerations. The following quotes indicate that economic concerns strongly motivated participants to regulate their reproduction:

> I joined the family planning program so that I would not be stricken poor .. miserably have to hold my baby on my chest and my back. (*Ikut KB biar tidak terlalu kere..... terlalu*

*sengsara anak mesti digendong di depan, di belakang.....*) (FGD.SSR-W2)

We are poor -- if we stop having children we could work in the field...do all kinds of work. (*Ekonomi kami lemah - kalau tidak punya anak lagi kami bisa kerja di sawah...kerja macem-macem)* (FGD.SSR-W2)

The children will not be well attended if (I) do not join the family planning program. Education costs are very burdensome.(*Anak tidak terurus kalau tidak KB. Biaya sekolah sekarang berat.*) (FGD.SSU-W1)

If we have many children, every academic year -- oh my, oh my... I have to get loan... I need to hold my breath for three years (to pay the installment). I will need a lot of funds -- for example when children are sick, I would need to sell my land or property to pay for their medical costs. So it would really be troublesome if we had many children. Too many unexpected expenditures. *(Jika anak banyak taon ajaran baru...waduh ... waduh ….perlu ambil utangan ..tahan napas selama tiga tahun (bayar angsuran). Banyak biaya - umpamanya anak sakit, terpaksa jual tanah untuk pengobatan*. *Jadi memang repot kalau banyak anak itu. Banyak pengeluaran tidak terduga*.) (FGD.LR-W2)

The following quotes describe how the community's religious and cultural values and perceptions of gender norms affected decisions to participate or not participate in the family planning program.

We believe that each child brings his or her own fortune... It is God's almightiness. Therefore I do not join the family planning program.(*Kita yakin bahwa anak itu ada rejekinya..kuasa Tuhan. Jadi saya tidak ikut KB*) (FGD.SSU-W1)

There were no problems between husband and wife. The problem was that I felt very disappointed after giving birth... I felt depressed. I felt depressed for three months. I could not deceive myself (of my disappointment). I gave birth to another girl. I, therefore, am strongly motivated to keep joining the program. (*Kalau hubungan suami istri ngga ada masalah. Cuma masalahnya habis melahirkan itu saya kecewa - saya stress. Dalam keadaan tiga bulan saya stress ngga bisa bohongi diri saya sendiri, saya melahirkan anak perempuan lagi. Makanya saya berambisi tetap berKB.)* (FGD.LU-W2*)*

I wanted to join the program. I am exhausted by taking care of my children. I do not have the patience to take care of children anymore. Since before we were married, I have told him that I would like to practice family planning. (*Aku yang ingin ikut KB. Cape ngurus anak. Males ngurus anak. Dari sejak dulu sebelum saya kawin saya sudah bilang saya mau KB.)* (FGD.SSU-W1)

I was embarrassed. I would like to use the IUD, but the doctor was a man. (*Malu saya - mau pakai spiral tetapi dokternya lelaki*) (FGD.SSU-W1)

**2. Reproductive Control and Decision-making Processes**

The FGDs revealed that women did not make independent decisions regarding reproduction. The following quotes indicate how spouses and significant others play important roles in reproductive decision-making -- and also how women sometimes ignored their husbands' desires.

**a. Conflict with Husband**

I did not know that I was already two month pregnant. I tried to abort it - he [husband] did not agree. It was born a boy. My husband asked for sterilization after the baby was born. *(Saya engga tahu sudah tahu sudah hamil dua bulan. Saya coba gugurkan 'ga mau dia. Lahir laki-laki. Semenjak (bayi itu) lahir suami saya minta disteril.)* (FGD.LR-W2)

My husband was angry, but not anymore. He accepted my decision [to join the family planning program]. *(Suami saya marah, tetapi sekarang enggak. Dia sudah setuju.) (*FGD.LU-W1)

I was weary, no relatives to help me. My husband asked me how could I gave birth to another girl. He did not agree with my decision to practice family planning. But that's alright. I just did it without his consent. *(Saya cape, tidak ada sanak famili yang membantu. Suami tanya, gimana sih kamu ini? Saya melahirkan lagi perempuan, suami belum ngizinin KB. Ya sudah, saya nyolong saja. Saya KB tanpa setahu dia.)* (FGD.LU-W2*)*

When I asked (my husband) If I could join FP, my husband was afraid. He asked me to use traditional herbs. I took his advice, and I was pregnant again. I said to myself that I could not go on like this. I decided to use injection.( *Saya mau ikut KB, suami saya takut. Udahlah minum jamu saja dulu, katanya. Kita ikutin apa saran suami. Ternyata kebobolan. Wah seperti ini kita tidak bisa dong. Udahlah ikut KB.)* (FGD.LU-W1)

**b. Support from Husband**

When a wife keeps giving birth to children, her man also becomes unhealthy. What if the wife is ill? The children get ill, and the man would also get sick. How then would he perform his work? *(Istri yang terus punya anak kecil, lelaki jadi ikut tidak sehat. Bagaimana kalau istri sakit, anak sakit, kita ikut sakit. Bagaimana akan menjalankan pekerjaan kita?)* (FGD.SSR-M)

The one who suggested to join the program was my husband. It's also for his peace of

mind. I thought he liked it.*(Yang menganjurkan KB dia (suami). Jadi kan dia enak juga. Mungkin agak senang.)* (FGD.SSU-W2)

We thought having six children was more than enough. Thinking about the expense, I realized that I had to give it up. I use condom. Just to release it (sexual desire). *(Karena kita pikir sudah cukup enam (anak), memikirkan biaya. Terpaksa kita mengalah. Saya pakai kondom. Sekadar melepaskan nafsu.)* (FGD.SSU-M)

**c. Extended Family's Influence**

According to my mother-in-law, however, practicing family planning is sinful... because children are God's gift... she continued to say that practicing family planning may cause side effects. Children may be deformed. *(Tapi menurut mertua: berdosa ikut KB.... karena itu (anak) kan karunia Tuhan... adalagi katanya, ikut KB kan ada efek samping. Anak bisa cacat.)* (FGD.SSU-W1)

**d. Advice of a Health Care Provider**

[Q: who decided the contraceptive for you?] Doctor Mahmud asked us to. *(P:Yang KB bapak itu siapa yang menentukan?) Dokter Mahmud yang menyuruh.*) (FGD.LR-W1*)*

**e. Political Motivation**

My reason for joining the family planning program is because it is a government program and my husband is a government employee.*(Alasan saya ikut KB pertama-tama karena itu program pemerintah, karena suami saya pegawai negeri, jadi dua anak saja cukup.*) (FGD.LR-W1*)*

**3. Experiences with Methods**

The women and men noted a range of experience using family planning methods, both positive and negative.

I feel safe (after sterilization). We do not have to worry about injection or IUD. (*Rasanya aman (sudah di steril). Kita tidak mikirin suntik..tidak mikirin spiral)* (FGD.SSU-W1*)*

I feel safe. I am sure by taking traditional herbs it [pregnancy] won't happen. *(Aman r-asanya. Saya yakin dengan minum jamu tidak akan jadi.)* (FGD.SSU-W1)

Initially (my husband) was doubtful ... he worried about side effects. Now it is okay since he has seen me doing fine. (*Pertama ragu-ragu….takut ada pengaruh efek samping. S-ekarang tidak ragu lagi dia (suami) karena dilihatnya saya sehat-sehat saja....)* (FGD.SSR-W2*)*

I am glad there are no side effects [of sterilization]. (*Saya senang karena tidak ada p-engaruh (dari KB steril))* - (FGD.SSU-W1*)*

Because of the hormonal injection, my wife's body has become skinnier. She has become very irritable. (*Dengan suntik istri saya badannya jadi kecil (kurus). Bawaannya sikapnya meringas melulu (mudah marah))*. (FGD.SSU-M*)*

I could not stand it...my eyes blurred [when taking the pill] - so I stopped and switched to the injection. But it was the same -- I could not stand it. It does not suit me. (*Ndak tahan..mata kabur (kalau pakai pil) - akibatnya lepas terus ganti KB suntik. KB suntik begitu juga - tidak tahan, tidak cocok.)* (FGD.SSU-W2*)*

Since I had that injection, I felt no sexual desire for my husband. When he asked me, I felt reluctant. My husband had become temperamental since then -- because I was unresponsive for sex. *(Sejak pake suntik itu, kalau saya hubungkan dengan suami saya, saya jadi males. Kalau diajak saya malas melayani gitu. Sejak suntik itu suami saya sering marah, soalnya saya malas hubungan seks.)* (FGD.LU-W2)

**4. Psychological Well-being**

**a. Perception of Oneself and One's Family**

Female participants:

I was embarrassed ... people were talking about me. My daughter cried when she was ridiculed for her mother being pregnant again *(Malu di sekolah (saat mengantar anak), diomongin oleh kawan-kawan. Anak sering nangis diolok-olok perihal ibunya hamil lagi.)* (FGD.SSR-W1*)*

I could wear lipstick and stylish clothes.*(Bisa pakai lipstick, bisa pake baju 'stil')* (FGD.SSR-W1*)*

If we always give birth our body will shrink, it gets skinnier fast, older fast *(Kalau kita melahirkan terus badan kita cepat menyusut, cepat kecil, cepat tua.*) (FGD.SSR-W1*)*

I used to have a fine body. Because of family planning I suffer from side effects. I tried (to reshape my body) through fitness workout, but I was not very successful. I am taking pills, so my breasts get smaller *(Dulu badan bagus. Gara-gara KB jadi ada efek sampingnya, berusaha ikut senam, tapi gimana gitu. Kita ikut KB, pil, kempes teteknya...)* (FGD.SSU-W1)

Male participants*:*

> My wife is proud of not holding babies anymore. *(Istri bangga, tidak bawa anak kecil lagi.)* (FGD.SSR-M)

> My wife did not feel confident [when she used family planning]. Her skin looked like someone with leprosy. (*Istri saya sendiri merasa minder. Kulitnya kayak kusta.)* (FGD.LU-M)

**b. Relationships**

Female participants:

Since the birth of HRT's eldest child, she felt very weak and was frequently ill. Her husband asked her to go to the doctor to be examined. He worried that HRT might be pregnant, but it turned out that she was not. Her husband suggested that HRT join KB [the family planning program]. Her parents also supported his decision for her to use modern contraceptives (injection). At the time of the FGD, her oldest child was two years old and she was healthy. (FGD.SSR-W2)

Other women reported that using family planning caused problems in their relationships with their husbands:

> There was a feeling of shame every time we were about to have sex. My husband was afraid that it [contraceptive method] might affect the body. But he could not wait any longer. (If) he has to wait too long, he will find it from another.(*Ada perasaan malu saat mau campur dengan suami.Kadang suami ragu kalau-kalau ada pengaruh di badan. Tetapi lama-lama menunggu tidak tahan. Kelamaan menunggu bisa serong mencari yang lain.)* (FGD.SSR-W2)

> My husband was mad. I was so tired. I did not want to have sex. *"Bapak jadi marah. Saya lagi capek dan repot, tidak mau diajak berhubungan badan." (FGD.SSU-W1)*

Male participants:

> I support KB [the family planning program] wholeheartedly. Why? For example, during Ramadhan if we had many children, we might not be able to buy new clothes. I was the one who proposed (using contraceptive) and she agreed. For me, it is okay to have only one child for the time being. *Kalau saya masalah KB itu saya mendukung sepenuhnya. Mengapa begitu, kalau kita contohkan, mau Lebaran kita punya anak banyak, tidak bisa beli baju baru. Memang rencana itu dari saya. Saya bisikkan ke istri, dia juga mendorong. Kalau bagi saya sementara punya anak satu saja dulu, tidak masalah.* (FGD. LR-M)

If my wife is frigid, I get angry. She is afraid. I said to her, "I will take you back to your parents if you treat your husband in such a [cold] way. She was cold once and I took her to her father. I said to him, "I do not want to have an affair. After all, I was born into a religious family. So please help convince her to treat me wholeheartedly". She was then counseled by her father. Now she is fine with me. *(Kalau istri saya dingin, saya marah. Istri saya takut. Saya bilang: 'Saya pulangkan kamu ke orangtua kamu kalau melayani suami begitu caranya.' Pernah dia dingin, saya pertemukan dengan ayahnya. Saya bilang: saya nggak mau nyeleweng di luar. Biar bagaimana saya ini punya darah kiai. Jadi tolong pak, supaya anak bapak (istri S) mau melayani saya dengan sepenuh hati. Dia terus dinasehati ayahnya. Sekarang sudah bagus pelayanannya.)* (FGD.LU-M*)*

**c. Work and Family Life**

The benefit of family planning is freedom. I can go wherever I like. At home nobody is trailing me crying. *(Manfaat KB: bebas. Mau kemana aja bisa. Ya di rumah juga nggak ada yang nangis-nangis lagi.)* (FGD.LR-W1)

Free... I could go visit my relatives. I can do my business -- selling materials. *(Bebas. Bisa pergi-pergi ke rumah saudara. Sambil bisnis, jual-jual kain.)* (FGD.LR-W2)

I could not work in the field when my kids were babies. I feel pity for the baby that I held. Once we did not have small children anymore, we could work to our satisfaction. I am as strong as my husband, man one spade and woman one spade. With family planning we could easily complete our jobs. Nobody is going to pee, defecate, and cry. *(Mau kerja lagi di kebun, kalau anak masih kecil tidak bisa. Kasihan dengan anak yang digendong. Kalau tidak punya anak lagi (anak sudah besar) kita juga dapat bekerja dengan puas hati. Sama kuat dengan suami bekerja di kebun, laki satu cangkul, kita satu cangkul. Dengan KB bisa ringan pekerjaan-pekerjaan beres. Kalau tidak ada yang kencing, berak, menangis.)* (FGD.SSR-W1*)*

I could join the PKK, Holy Koran reading, because no children are tailing me. It is also true with my husband -- nothing bothers our (sexual) relationship. There are only the two of us now in the bedroom, no small children anymore. *(Bisa ngikutin PKK, mau pengajian kita bebas, tidak dibuntuti anak lagi. Suami juga begitu, dekati kita tidak ada lagi yang ganggu. Tidur sudah berdua, tidak lagi sama anak-anak kecil.)* (FGD.SSU-W1)

A woman with many small children cannot go anywhere. Even though we are village women, we also want to go sightseeing to the city. I am glad I could go to my husband's workplace, join in the social gathering, without much trouble. Also, fewer costs for children's education. *(Perempuan kalau punya anak kecil tidak punya kesempatan ke*

*mana-mana. Kami dari dusun pengen juga jalan-jalan ke kota, suami ingin kami nggak sibuk. Senang bisa ikut suami kerja, bisa ikut ngumpul-ngumpul, tidak banyak gangguan. Biaya anak sekolah sedikit.)* (FGD.SSR-W2*)*

When I started taking pills, I got kind of lazy feeling about work. *(Setelah KB dengan pil, bekerjanya kurang giat. Menurun.)* (FGD.SSU-W2*)*

**5. Summary of the Focus Group Discussions**

Women (and their partners) considered many factors when deciding whether to participate in the family planning program. The most common factor considered was time for children and husbands. Women believed that controlling their reproduction would give them better opportunities to attend to their children's and husbands' needs. Second, participants were aware that they came from low-income families and that having a lot of children would impose a great financial stress on the family. Third, women wanted time for other activities, for example, to participate in religious ceremonies, to mingle with friends, and to pursue a career.

The FGDs also revealed that participation in the family planning program was not an easy decision. In many instances women were confronted with values in the local culture (e.g., a son being more valued than a daughter), religious laws, and unsupportive husbands, which created in them internal conflicts between wanting to be good wives, and being able to care for the children they had and wanting to have more time for themselves. Women were also faced with having to use the available contraceptive methods that were not always suitable for their health and economic conditions.

Male participants also voiced concerns about their wives' participation in family planning. Men tended to focus on the economic benefits of family planning and claimed to support their wives' decision for contraceptive use. However, a number of participants were concerned about the effect of family planning on the appearance and sexual performance of their spouses.

Based on the findings from the FGDs, 50 items were included on the questionnaire. Of those, 42 measured psychological well-being and eight measured decision-making processes.

**B. Survey of Women**

**1. Background Characteristics**

**a. Sociodemographic Characteristics**

Survey data were collected from 800 respondents. However, four questionnaires could not be used. Thus, the final study sample included 796 women. Table 3 shows that the respondents in South Sumatra and Lampung were, on average, 30-33 years old. The mean age of their oldest child was 11-12, and the mean age of their youngest child was five. More than 95 percent of the

women were Moslem (not shown in a table). On average, the women married before they were 20. In Tanjung Beringin, in rural South Sumatra, the average age of marriage -- 16.8 years -- was the youngest[1]. Those living in the rural areas tended to marry younger than those living in the cities, with the exception of women in Bandar Jaya in rural Lampung.

Women living in urban areas had higher levels of education than women in rural areas, with the exception of women from rural Bandar Jaya. Women from there had the highest reported level of education (10 years, or completion of junior high school). The average number of years of education in other areas suggested that most women completed elementary school.

**Table 3 : Sociodemographic Background, Study Sites in South Sumatra and Lampung, 1996.**

| Characteristics | South Sumatra | | | Lampung | | | |
|---|---|---|---|---|---|---|---|
| | Urban | Rural | | Urban | | Rural | |
| | Duku (n=198) | Tanjung Beringin (n=85) | Perangai (n=112) | Tanjung Karang Pusat (n=101) | Pantai Panjang (n=99) | Gunung Sugih (n=100) | Bandar Jaya (n=101) |
| Mean age: | | | | | | | |
| respondent | 31.9 | 30.8 | 30.4 | 31.9 | 32.0 | 30.3 | 33.2 |
| spouse | 36.6 | 36.9 | 36.6 | 37.1 | 37.6 | 37.0 | 37.5 |
| first born | 10.6 | 11.7 | 11.9 | 11.6 | 11.7 | 10.6 | 11.6 |
| youngest child | 5.1 | 5.1 | 4.7 | 4.8 | 5.4 | 5.1 | 5.0 |
| Mean age at marriage | 19.2 | 16.8 | 17.1 | 19.0 | 18.1 | 17.9 | 19.8 |
| Years of education completed: | | | | | | | |
| respondent | 7.9 | 6.0 | 6.1 | 8.7 | 7.6 | 7.0 | 10.0 |
| spouse | 8.7 | 6.3 | 6.7 | 9.5 | 9.0 | 7.4 | 10.8 |
| Work status: | | | | | | | |
| homemaker | 61.1 | 31.8 | 34.8 | 70.3 | 66.7 | 46.0 | 55.4 |
| wage/income earner | 38.9 | 68.2 | 65.2 | 29.7 | 33.3 | 54.0 | 44.6 |
| Mean monthly income, in rupiah: | | | | | | | |
| respondent | 119,614 | 78,000 | 78,019 | 175,526 | 147,262 | 131,473 | 309,229 |
| spouse | 253,333 | 89,127 | 107,143 | 325,034 | 204,321 | 206,638 | 575,505 |

More respondents in rural than urban areas of both provinces reported working for income (with the exception of women in Pantai Panjang in Lampung). Women in South Sumatra were more likely to report working than were women in Lampung. The average income of women was

[1] According to the Marriage Law No. 1/1974, a woman is allowed to marry at the age of 16 or older. In practice, however, she can marry before she reaches 16 years and be legally married after obtaining consent from the local religious leader. Nationally, approximately 26.9 percent of married women married at the age of 16 or younger (CBS, 1994).

higher in urban areas, with the exception of Bandar Jaya. The participation of women from South Sumatra in work may be due to the fact that their family income is low. The villages in this province reveal the lowest family income and yet the highest participation of women in wage earning.

### b. Living Arrangements

In the rural areas, more than half of the respondents lived in their own houses -- especially those from Gunung Sugih village in Lampung. By contrast, in two of the three urban areas, only one-quarter to one-third of respondents lived in their own houses (Table 4).

Government-supplied electricity and water were largely available in the cities. In general, respondents living in Lampung had better facilities in their homes than those in South Sumatra. There were no clear patterns of living arrangements in nuclear or extended families between the provinces and between urban and rural areas.

**Table 4: Living Arrangements (in percent), South Sumatra and Lampung, 1996.**

| Characteristic | South Sumatra | | | Lampung | | | |
|---|---|---|---|---|---|---|---|
| | Urban | Rural | | Urban | | Rural | |
| | Duku (n=198) | Tanjung Bering (n=85) | Perangai (n=112) | Tanjung Karang Pusat (n=101) | Pantai Panjang (n=99) | Gunung Sugih (n=100) | Bandar Jaya (n=101) |
| Living arrangement: | | | | | | | |
| own house | 25.3 | 65.9 | 65.2 | 32.7 | 45.5 | 86.0 | 59.4 |
| other arrangement | 74.7 | 34.1 | 34.8 | 67.3 | 54.5 | 14.0 | 40.6 |
| Electricity available | 96.3 | 2.4 | 50.0 | 94.4 | 90.1 | 49.0 | 89.1 |
| Water supply: | | | | | | | |
| government | 64.1 | 0 | 0 | 52.5 | 78.6 | 0 | 10.9 |
| own well | 29.8 | 90.5 | 87.4 | 31.7 | 21.4 | 98.0 | 89.1 |
| other | 6.1 | 9.5 | 12.6 | 15.8 | 0 | 2.0 | 0 |
| Toilet available | 76.3 | 4.7 | 4.5 | 91.1 | 75.8 | 50.0 | 97.0 |
| Living in extended families | 28.3 | 16.5 | 24.1 | 31.7 | 25.3 | 11.0 | 26.7 |
| Living in nuclear families | 71.7 | 83.5 | 75.9 | 68.3 | 74.7 | 89.0 | 73.3 |

### 2. Pregnancy History

The mean age at first childbearing was lower in rural than urban areas (Table 5). Although rural Tanjung Beringin had the lowest age at first marriage, the respondents in this village did not differ significantly from those in other rural areas in terms of their mean age of first childbearing. Other aspects of pregnancy history indicators appeared very similar across districts and provinces. Women in urban Lampung, however, showed the highest percentages of unintended pregnancies.

In both provinces, more respondents in urban areas, especially in Palembang and Bandar Lampung, said they attempted to terminate one or more pregnancies. Women in rural Bandar Jaya had similar patterns of pregnancy termination as women in urban areas.

**Table 5: Pregnancy History, South Sumatra and Lampung, 1996.**

| Characteristic | South Sumatra | | | Lampung | | | |
|---|---|---|---|---|---|---|---|
| | Urban | Rural | | Urban | | Rural | |
| | Duku (n=198) | Tanjung Beringin (n=85) | Perangai (n=112) | Tanjung Karang Pusat (n=101) | Pantai Panjang (n=99) | Gunung Sugih (n=100) | Bandar Jaya (n=101) |
| Mean age at first child | 21.1 | 18.8 | 18.3 | 20.0 | 19.5 | 19.7 | 21.2 |
| Mean no. pregnancies | 3.4 | 3.7 | 3.9 | 3.5 | 3.8 | 2.9 | 3.4 |
| Mean no. children ever born | 3.2 | 3.6 | 3.8 | 3.3 | 3.6 | 2.8 | 3.2 |
| Mean no. children still living | 3.0 | 3.1 | 3.2 | 3.0 | 3.1 | 2.6 | 3.1 |
| Mean no. live births<br>boys<br>girls | 3.1<br>1.6<br>1.5 | 3.5<br>1.8<br>1.6 | 3.6<br>1.8<br>1.8 | 3.2<br>1.6<br>1.6 | 3.5<br>1.8<br>1.7 | 2.7<br>1.4<br>1.3 | 3.2<br>1.6<br>1.6 |
| Mean no. still births | 0.1 | 0.1 | 0.2 | 0.1 | 0.1 | 0.1 | 0.0 |
| Mean no. miscarriages | 0.2 | 0.1 | 0.1 | 0.2 | 0.2 | 0.1 | 0.2 |
| Percent women who had an unintended pregnancy | 24.1 | 25.0 | 28.0 | 34.7 | 30.3 | 13.0 | 15.0 |
| Percent of women with unintended pregnancy who terminated that pregnancy | 25.0 | 5.9 | 9.1 | 36.4 | 24.1 | 8.3 | 20.0 |

### 3. Use of Family Planning

Table 6 shows the proportion of women who used or had used family planning, as well as those who have never used or were not using at the time of the survey. Most women (73 to 96 percent) had experience with using family planning. The proportion of women who had never used family planning ranged from 27 percent in Perangai (rural South Sumatra) to just 4 percent in Tanjung Karang Pusat (urban Lampung).

A high proportion of women reported that they or their husband were using family planning at the time of the survey; overall, 74 percent of women or their husbands were currently using some type of contraceptive method, and 85.9 percent had ever used family planning (data not shown). Contraceptive prevalence ranged from 61 percent in Perangai to 86 percent in Gunung Sugih (Table 6). Use of modern methods accounted for the large majority of this contraceptive use. In the rural South Sumatra study sites, Tanjung Beringin and Perangai, all or virtually all of contraceptive users were using modern methods. Use of traditional methods was highest in the two urban Lampung sites, Tanjung Karang Pusat (15 percent) and Pantai Panjang (17 percent).

**Table 6: Use of Family Planning (In Percent), Married Women Aged 15-49, South Sumatra and Lampung, 1996.**

| Family planning status | South Sumatra | | | Lampung | | | |
|---|---|---|---|---|---|---|---|
| | Urban | Rural | | Urban | | Rural | |
| | Duku (n=198) | Tanjung Beringin (n=85) | Perangai (n=112) | Tanjung Karang Pusat (n=101) | Pantai Panjang (n=99) | Gunung Sugih (n=100) | Bandar Jaya (n=101) |
| Never used family planning | 19.2 | 17.6 | 26.8 | 4.0 | 8.2 | 5.0 | 11.9 |
| Ever used family planning | 80.8 | 82.4 | 73.2 | 96.0 | 91.8 | 95.0 | 88.1 |
| Ever used modern method | 75.8 | 82.4 | 73.2 | 90.0 | 85.8 | 95.0 | 84.1 |
| Not currently using family planning | 33.8 | 25.9 | 39.3 | 15.8 | 20.2 | 14.0 | 14.9 |
| Currently using family planning | 66.2* | 74.1 | 60.7 | 84.2* | 79.8* | 86.0 | 85.1 |
| Currently using modern method | 56.1 | 74.1 | 59.8 | 73.3 | 67.7 | 84.0 | 76.2 |
| Currently using traditional method | 11.1 | - | 0.9 | 14.9 | 17.2 | 3.0 | 9.9 |

Note: The sum of the percent of women "currently using a modern method" and the percent "currently using a traditional method" may be greater than the percent "currently using contraception" because some women and their husbands were using both a modern and a traditional method.

Table 7 presents the breakdown of contraceptive use by method, among women who were using or had ever used contraception. The data shown reflect the National family planning program's promotion of Effective Integrated Contraceptives (MKET, which consists of IUD, implant, injection, and tubectomy or vasectomy) Women generally reported use of hormonal methods of contraception, particularly the injection, although comparison between current use and ever-use figures indicated a fair amount of method switching. This may be due to side effects common among some methods, particularly bleeding.

**Table 7: Current Use and Ever-use of Contraception, by Method, Ever-married Women Aged 15-49, S Lampung, 1996.**

| Method of contracep-tion | South Sumatra | | | | | | Lampung | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Urban | | Rural | | | | Urban | | | | |
| | Duku (n= 198) | | Tanjung Beringin (n=85) | | Perangai (n=112) | | Tanjung Karang (n=101) | | Pantai Panjang (n=99) | | Gunu (n= |
| | current use | ever-use | current use | ever-use | current use | ever-use | current use | ever-use | current use | ever-use | current use |
| Pill | 10.1 | 35.4 | 15.3 | 38.8 | 16.1 | 44.6 | 28.7 | 59.4 | 29.3 | 72.7 | 28. |
| IUD | 4.6 | 11.1 | 4.7 | 5.9 | 0.9 | 4.5 | 7.9 | 14.9 | 5.1 | 9.1 | 5. |
| Injection | 25.8 | 46.5 | 3.5 | 9.4 | 14.3 | 17.0 | 32.7 | 91.1 | 20.2 | 53.5 | 24. |
| Implant | 4.0 | 5.6 | 47.1 | 51.8 | 27.7 | 42.0 | 2.0 | 2.0 | 11.1 | 12.1 | 23. |
| Condom | 3.0 | 6.6 | 1.2 | 1.2 | - | - | 1.0 | 5.0 | 1.0 | 6.1 | |
| Tubectomy | 8.1 | 8.1 | 2.4 | 2.4 | 0.9 | 0.9 | 1.0 | 1.0 | 1.0 | 1.0 | 4. |
| Vasectomy | 0.1 | 0.1 | - | - | - | - | - | - | - | - | |
| Rhythm/ abstinence | 4.5 | 8.6 | - | - | 0.9 | 0.9 | 5.0 | 10.0 | 4.0 | 8.1 | 1. |
| Coitus interruptus | - | 2.5 | - | - | - | - | 2.0 | 4.0 | - | 1.0 | 1. |
| Lactation | 1.0 | 6.1 | - | - | - | - | 6.9 | 10.9 | 6.1 | 18.2 | |
| Traditional Herbs | 5.6 | 10.6 | - | - | - | - | 4.0 | 8.9 | 10.1 | 23.2 | 1. |
| Massage | 2.5 | 4.5 | - | - | - | - | 1.0 | 5.0 | 5.1 | 13.1 | |

The current and ever-use data show some striking patterns of method mix by location. For example, current use of the injection in Tanjung Beringin and Perangai (rural South Sumatra) was much less common than in any other location. In both provinces, implant use was generally higher in rural than urban areas. IUD use was less than 9 percent in all locations, except in Bandar Jaya, where 19 percent of the women reported current use of the IUD. Women in South Sumatra were the most likely to report having had a tubectomy (8 percent). Use of male methods and traditional methods was generally low in all locations, although again, the patterns of use varied.

**4. Factor Analysis of Psychological Well-being**

On the questionnaire, 42 items were constructed to measure psychological well-being. Those items were written in ordinal scales and grouped into five components: general life satisfaction, relationships, role fulfillment, personal matters, and negative feelings. Factor analysis, which is a statistical technique used to identify a small number of factors that can represent relationships among a large number of variables, was performed to examine whether the items "grouped" together under the five components on the questionnaire. A cut-off point of .4 was used for items to be used in a particular scale. Scales were transformed into positive scales so that the direction of responses was consistent for the factor analysis. Transformation was also used to standardize the variations of the components into one standard deviation. One variable, satisfaction with work and career, was not included in the computation due to the high number of missing values. Varimax rotation was conducted to minimize the number of variables that had a high loading on one factor. Factors were extracted through principal component analysis which measures the eigen value of a composite variable. Variables with eigen values equal to or greater than one were treated as separate factors.

The factor analysis of 41 variables yielded ten factors representing various indicators of psychological well-being. The factors were similar to, but not exactly the same as, the categories of items included on the questionnaire. Table 8 summarizes the results of the factor analysis, and indicates which variables "loaded" with the ten factors and which variables were associated with factors other than their primary factor. Further analysis on psychological well-being in this report will be based on the factor scores of these ten factors:

1) personal stress
2) satisfaction in relationships
3) satisfaction with family welfare
4) role stress
5) child care and domestic responsibilities
6) ability to attend to economic and social needs
7) vitality
8) time for self and others
9) shame
10) reproductive control.

**Table 8: Results of Factor Analysis on Psychological Well-being Questions.**

| No. | Factor label | Variable Number* | Variable label | Factor 1 | Factor 2 | Factor 3 |
|---|---|---|---|---|---|---|
| 1 | Personal stress | V081 | In doubt and conflict | .74836 | | |
| | | V082 | Feel guilty | .73702 | | |
| | | V080 | Unable to overcome my personal problems | .70169 | | |
| | | V076 | Angry with myself | .62892 | | |
| | | V075 | Doubtful and feeling anxious regarding my ability to control reproduction | .59647 | | |
| | | V077 | Angry with other persons (husband, children) | .57639 | | |
| | | V079 | Need support/help from extended family and neighbors | .56296 | | |
| | | V070 | Helpless in handling family matters | .51346 | | |
| | | V074 | Uncertain about my future family life | .48799 | | .32755 |
| 2 | Satisfaction in relationships | V048 | Relationship with extended family | | .82534 | |
| | | V047 | Relationship with children | | .81850 | |
| | | V046 | Relationship with husband | | .79910 | |
| | | V049 | Relationships with friends and neighbors | | .79827 | |
| | | V050 | Sexual relationship (sexual life) | | .76132 | |
| | | V051 | Relationship with a supreme being (religious life) | | .47427 | .30623 |
| 3 | Satisfaction w/ family welfare | V043 | Family income | | | .71994 |
| | | V060 | Ability to fulfill family's financial needs | | | .64265 |
| | | V041 | Life as a whole | | | .63906 |
| | | V044 | Ability to manage family | | .35958 | .41523 |
| 4 | Role stress | RV072 | Overwhelmed by responsibilities as a mother | | | |
| | | RV071 | Overwhelmed by responsibilities as a wife | | | |
| | | RV069 | Disappointment with family life | .39483 | | |

**Table 8 Continued: Results of Factor Analysis on Psychological Well-being Questions**

| | | | | | | |
|---|---|---|---|---|---|---|
| **5** | **Child care and domestic responsibilities** | **RV057** | **Marital problems due to child care/domestic work** | | | |
| | | **RV058** | **Husband lacks understanding of my problems** | | | |
| | | **RV054** | **Cannot visit relatives due to child care** | | | |
| | | **RV059** | **Overwhelmed by domestic responsibilities** | | | |
| | | **RV062** | **Difficulty in child care/childrearing** | | | |
| **6** | **Ability to attend to economic and social needs** | **V055** | **Have extra time for involvement in activities such as PKK** | **.66311** | | |
| | | **V061** | **Have the opportunity to earn an income** | **.65969** | | |
| | | **V065** | **Have the opportunity to do things that interest me** | **.55200** | | |
| **7** | **Vitality** | **V063** | **Have no problems with health and illnesses** | | **.80240** | |
| | | **V042** | **Feeling okay with my health** | | **.62841** | |
| | | **V068** | **Feeling free** | **.33192** | **.43435** | |
| **8** | **Time for self and others** | **V053** | **Have enough time with children** | | | **.69519** |
| | | **V056** | **Have time to socialize** | **.43962** | | **.61487** |
| | | **V064** | **Have time to take care of oneself** | | | **.47721** |
| | | **V067** | **Feeling useful to others** | | **.37564** | **.43900** |
| **9** | **Shame** | **RV078** | **Bothered by my family being a burden to the extended family** | | | |
| | | **RV066** | **Feel ashamed of my appearance** | | | |
| | | **RV073** | **Feel ashamed of my own family** | | | |
| **10** | **Reproductive control** | **V045** | **Ability to postpone and prevent pregnancy** | | | |

*R before a variable number indicates the response was transformed from negative to positive so that all factors would be comparable.

## 5. Contraceptive Use and Psychological Well-being

In this section, the ten factors of psychological well-being were related to aspects of contraceptive use to assess the relationship, if any, between contraceptive use and women's perceived well-being. Well-being among contraceptive users and non-users was compared first. We also compared: users of modern vs. traditional methods; urban vs. rural residents; women who worked vs. those who did not work; women living in nuclear vs. extended families; and women who discontinued an unintended pregnancy vs. those who continued the pregnancy. It should be noted that this analysis was not designed to test causal relationships; because the data are cross-sectional, we cannot determine whether contraceptive use (or any other variable) preceded or followed a state of psychological well-being.

### a. Psychological Well-being among Contraceptive Users and Non-users

A comparison of users and non-users of contraception on measures of psychological well-being showed that users and non-users were significantly different on three indicators of psychological well-being (Table 9). Contraceptive users felt more satisfied with their relationships with others and felt they had greater control over their reproductive lives. On the other hand, they experienced a higher level of role stress than non-users.

**Table 9: Mean Scores of Psychological Well-being among Non-users and Current Users of Contraception, South Sumatra and Lampung, 1996.**

| Factor of psychological well-being | Non-users (n=115) | | Current users (n=447) | | t-value |
|---|---|---|---|---|---|
| | Mean score | SD | Mean score | SD | |
| Personal stress (-) | -0.09 | 1.02 | 0.02 | 0.99 | -1.67 |
| Satisfaction in relationships** | -0.22 | 1.04 | 0.06 | 0.98 | -2.67 |
| Satisfaction with family welfare | -0.16 | 1.14 | 0.04 | 0.96 | -1.83 |
| Role stress (-)* | 0.20 | 0.93 | -0.05 | 1.01 | 2.43 |
| Child care and domestic responsibilities (-) | 0.16 | 1.03 | -0.04 | 0.99 | 1.96 |
| Ability to attend to economic/social needs | -0.10 | 0.94 | 0.03 | 1.02 | -1.15 |
| Vitality | -0.98 | 1.12 | 0.03 | 0.96 | -1.08 |
| Time for self and others | -0.11 | 1.15 | 0.03 | 0.96 | -1.29 |
| Shame (-) | -0.01 | 1.08 | 0.00 | 0.98 | -0.14 |
| Reproductive control** | -0.26 | 1.10 | 0.07 | 0.96 | -3.06 |

(-) indicates score was transformed from negative to positive. SD = standard deviation. Significance of difference between mean scores was tested with a t-test. ** indicates significant at $p<0.01$. * indicates significant at $p< 0.05$.

### b. Psychological Well-being among Users of Traditional and Modern Contraception

Compared to users of traditional contraception, users of modern contraception tended to feel more satisfied with their relationships, more satisfied with child care and domestic responsibilities, and better able to attend to their economic and social needs (Table 10). It could be that modern contraceptive users felt more protected from unintended pregnancy during sex and were therefore able to maintain better relationships with their spouses than women using traditional methods. It is possible that users of traditional methods used such methods for health reasons or due to their husbands' resistance to modern methods, and they thus may have felt some dissatisfaction towards their spouses. Users of traditional methods might have felt less satisfied than users of modern methods with their child care and domestic responsibilities and less able to attend to their economic and social needs due to having more children.

**Table 10: Mean Scores of Psychological Well-being among Users of Modern and Traditional Contraception, South Sumatra and Lampung, 1996.**

| Factor of psychological well-being | Users of modern contraceptives (n=401) | | Users of traditional contraceptives (n=30) | | t-value |
|---|---|---|---|---|---|
| | Mean score | SD | Mean score | SD | |
| Personal stress (-) | 0.03 | 0.99 | -0.03 | 1.08 | 0.32 |
| Satisfaction in relationships* | 0.08 | 0.97 | -0.29 | 1.12 | 2.02 |
| Satisfaction with family welfare | 0.02 | 0.95 | 0.33 | 1.07 | -1.68 |
| Role stress (-) | -0.04 | 0.99 | -0.11 | 1.06 | 0.39 |
| Child care and domestic responsibilities (-)* | -0.02 | 0.99 | -0.39 | 0.84 | 2.02 |
| Ability to attend to economic/ social needs** | 0.08 | 0.99 | -0.50 | 1.01 | 3.31 |
| Vitality | 0.03 | 0.95 | 0.06 | 1.26 | -0.20 |
| Time for self and others | 0.02 | 0.95 | -0.60 | 1.15 | 0.47 |
| Shame (-) | 0.01 | 0.96 | -0.15 | 1.20 | 0.91 |
| Reproductive control | 0.08 | 0.96 | -0.06 | 0.81 | 0.80 |

(-) after a factor indicates the score was transformed from negative to positive. Significance of difference between mean scores was tested with a t-test. ** indicates significant at $p<0.01$. * indicates significant at $p< 0.05$.

### c. Psychological Well-being among Different Types of Contraceptive Users

Among contraceptive users of the three most commonly used methods, we used one-way analysis of variance (ANOVA) to assess the relationship between the contraceptive method used and ten factors of women's psychological well-being. In each ANOVA model, the independent variable

was the contraceptive method used (pill, IUD/implant, or injection), and the dependent variable was a psychological well-being factor score. The results of the 10 ANOVA models are presented in Table 11. The Scheffe multiple-comparison test was used to test the statistical significance of differences in scores of psychological well-being between users of different contraceptive methods. The test examines the significance of differences for three comparisons: pill users vs. IUD/implant users; pill users vs. injection users; and IUD/implant users vs. injection users.

**Table 11: Mean Scores of Psychological Well-being among Users of Different Methods of Contraception, South Sumatra and Lampung, 1996.**

| Factor of psychological well-being | Mean score on psychological well-being factor | | | F-ratio | Significant relation-ships* |
|---|---|---|---|---|---|
| | Pill users (n=112) | IUD/implant users (n=129) | Injection users (n=137) | | |
| Personal stress (-) | .12 | .02 | -.05 | 0.903 | - |
| Satisfaction in relationships | .18 | -.05 | .12 | 1.803 | - |
| Satisfaction with family welfare | -.09 | -.13 | .17 | 3.811 | bc |
| Role stress (-) | -.09 | -.01 | -.04 | 0.185 | - |
| Child care and domestic responsibilities (-) | -.01 | .05 | -.09 | 0.67 | - |
| Ability to attend to economic and social needs | .02 | .24 | -.08 | 3.56 | bc |
| Vitality | .11 | -.02 | -.01 | 0.626 | - |
| Time for self and others | .23 | -.06 | -.03 | 3.210 | - |
| Shame (-) | -.05 | -.08 | .13 | 1.751 | - |
| Reproductive control | .07 | -.01 | .12 | 0.656 | - |

*ab=significant between pill and IUD/implant; ac=significant between pill and injection; bc=significant between IUD/implant and injection. Significance tested with Scheffe test at .05 level
Note: (-) after a factor indicates the score was transformed from negative to positive.

We found a statistically significant difference between IUD/implant users and injection users for two factors of psychological well-being: "satisfaction with family welfare" and "ability to attend to economic and social needs" (Table 11). Women who were using the IUD and the implant were significantly less satisfied with their family welfare than injection users. This might be due to the fact that those women targeted for IUD and implant use by the family planning program tend to live in rural areas and be the most economically disadvantaged groups in the country.

IUD and implant users felt they had more time to attend to their economic and social needs than injection users. This may be because IUD and implant users are trying to space their children by several years or to end childbearing, while injection users are more likely to be spacing their children by fewer years and are unlikely to be ending childbearing. Thus, IUD/implant users are less likely than injection users to have young (pre-school age) children to care for. With fewer children in the home during the day, they are able to focus on activities other than childbearing and childrearing.

### d. Psychological Well-being among Rural and Urban Women

Psychological well-being differed significantly between rural and urban women on six out of ten factors (Table 12). Urban women perceived higher levels of personal stress and felt less able to attend to economic and social needs than did rural women. On the other hand, urban women felt more satisfied with their family welfare, perceived that they had more time for themselves and for others, and felt more able to control their reproduction than women living in the rural areas. Urban women also scored significantly higher on perceived vitality than rural women.

These differences likely reflect the different lifestyles of women in urban and rural areas. Life in urban areas tended to be faster paced and more stressful, and urban homes are more likely to enjoy amenities such as electricity and indoor plumbing. A variety of family planning services are also more easily available in urban areas. In rural areas, more women reported working, which may explain why rural women felt better able to attend to economic and social needs than did women in urban areas.

**Table 12: Mean Scores of Psychological Well-being Between Rural and Urban Women, South Sumatra and Lampung, 1996.**

| Factor of psychological well-being | Rural (n= 296) | | Urban (n=266) | | t-value |
|---|---|---|---|---|---|
| | Mean score | SD | Mean score | SD | |
| Personal stress (-) ** | 0.12 | 0.98 | -0.13 | 1.01 | 2.92 |
| Satisfaction in relationships | -0.06 | 0.95 | 0.07 | 1.05 | -1.51 |
| Satisfaction with family welfare** | -0.20 | 0.95 | 0.23 | 1.01 | -5.18 |
| Role stress (-) | -0.04 | 0.99 | 0.40 | 1.01 | -0.89 |
| Child care and domestic responsibilities (-) | 0.05 | 0.95 | -0.05 | 1.05 | 1.21 |
| Ability to attend to economic/social needs** | 0.32 | 0.81 | -0.36 | 1.07 | 8.35 |
| Vitality* | -0.08 | 0.92 | 0.09 | 1.08 | -1.90 |
| Time for self and others** | -0.10 | 0.78 | 0.11 | 1.19 | -2.52 |
| Shame (-) | 0.02 | 0.94 | -0.02 | 1.07 | 0.40 |
| Reproductive control* | -0.08 | 0.81 | 0.09 | 1.17 | -2.05 |

(-) after a factor indicates the score was transformed from negative to positive. SD indicates standard deviation. Significance of difference between mean scores was tested with a t-test.

* indicates significant at $p< 0.05$. ** indicates significant at $p<0.01$.

### e. Psychological Well-being among Women in Nuclear and Extended Families

Women living in nuclear families and women living in extended families differed significantly on two factors of psychological well-being (Table 13). Women in extended households tended to feel more shame with regard to themselves and their families than those in nuclear households. On the other hand, they felt more able to control their reproduction than those living in the nuclear family arrangements, perhaps due to crowded living conditions and less opportunity for having sex.

**Table 13: Mean Scores of Psychological Well-being Between Women in Nuclear and Extended Families, South Sumatra and Lampung, 1996.**

| Factor of psychological well-being | Nuclear family (n=427) | | Extended family (n=135) | | t-value |
|---|---|---|---|---|---|
| | Mean score | SD | Mean score | SD | |
| Levels of personal stress (-) | 0.004 | 1.01 | -0.01 | 0.98 | 0.16 |
| Levels of satisfaction in relationships | -0.01 | 0.97 | 0.04 | 1.11 | -0.53 |
| Satisfaction with family welfare | -0.002 | 1.02 | 0.01 | 0.93 | -0.07 |
| Role stress (-) | -0.03 | 1.10 | 0.09 | 0.96 | -1.19 |
| Child care and domestic responsibilities (-) | -0.04 | 1.01 | 0.12 | 0.95 | -1.83 |
| Ability to attend to economic/social needs | -0.02 | 1.02 | 0.05 | 0.95 | -0.73 |
| Vitality | -0.03 | 0.98 | 0.09 | 1.05 | -1.14 |
| Time for self and others | -0.01 | 0.97 | 0.04 | 1.09 | -0.53 |
| Shame (-)* | 0.05 | 0.96 | -0.17 | 1.09 | 2.27* |
| Reproductive control* | -0.05 | 1.00 | 0.16 | 0.98 | -2.07* |

(-) after a factor indicates the score was transformed from negative to positive. SD indicates standard deviation. Significance of difference between mean scores was tested with a t-test. * indicates significant at $p < 0.05$.

### f. Psychological Well-being among Women of Differing Work Status

Working and non-working women differed on six of the ten factors of psychological well-being (Table 14). Work was defined as participating in any income-generating activity, whether in the formal or informal sector. Working women perceived lower levels of personal stress than non-working women. This could be due to the fact that rural women were more likely to work, and rural women perceived less personal stress in their lives (Table 12). Women who were working also felt better able to attend to economic and social needs than non-working women. However, working women also felt less satisfied with their family's welfare, and they were less likely to feel that they had enough time for themselves and others. In addition, working women felt less vitality and more ashamed of their families than women who did not earn any income.

**Table 14: Mean Scores of Psychological Well-being among Working and Non-working Women, South Sumatra and Lampung, 1996.**

| Factor of psychological well-being | Working | Not working | t-value |
|---|---|---|---|

| | (n=259) | | (n=303) | | |
|---|---|---|---|---|---|
| | **Mean score** | **SD** | **Mean score** | **SD** | |
| Personal stress (-)** | 0.14 | 0.85 | -0.12 | 1.10 | 3.16 |
| Satisfaction in relationships | -0.05 | 0.99 | 0.04 | 1.01 | -1.04 |
| Satisfaction with family welfare** | -0.12 | 0.94 | 0.11 | 1.04 | -2.73 |
| Role stress (-) | 0.01 | 1.05 | -0.01 | 0.96 | 0.17 |
| Child care and domestic responsibilities (-) | -0.05 | 1.08 | 0.05 | 0.93 | -1.16 |
| Ability to attend to economic and social needs** | 0.42 | 0.76 | -0.36 | 1.04 | 10.17 |
| Vitality* | -0.11 | 1.02 | 0.09 | 0.98 | -2.45 |
| Time for self and others* | -0.09 | 0.94 | 0.08 | 1.05 | -1.97 |
| Shame (-)** | -0.12 | 0.95 | 0.10 | 1.03 | -2.63 |
| Reproductive control | 0.06 | 0.98 | -0.05 | 1.01 | 1.21 |

(-) after a factor indicates the score was transformed from negative to positive. SD indicates standard deviation. Significance of difference between mean scores was tested with a t-test. * indicates significant at $p< 0.05$. ** indicates significant at $p<0.01$.

### g. Psychological Well-being among Women Who Experienced an Unintended Pregnancy

Women who had an unwanted pregnancy and continued the pregnancy (n=99) tended to feel less satisfied with their family welfare than those who discontinued the pregnancy (n=26) (data not shown). No significant differences were found on other factors of psychological well-being between women who continued an unintended pregnancy and those who terminated it.

### h. Psychological Well-being Differences by Women's Age and Number of Children

Since the average age of study participants was around 30 years, we decided to compare women who were 30 years old or younger and those older than 30 years in terms of their psychological well-being (data not shown). Younger women felt significantly more shame regarding themselves and their families than older women ($t = -3.56$, $p<0.001$). However, the two age groups did not differ significantly on any of the other nine factors of psychological well-being.

We also compared psychological well-being by number of children (data not shown). Women with two or fewer children differed significantly from women with more than two children on just two factors. Respondents with two or fewer children felt they had a higher degree of vitality than those with more than two children ($t = 2.31$, $p < 0.02$). In addition, respondents with fewer children felt they had more reproductive control than those with more children ($t= 2.28$, $p < 0.02$).

### i. Psychological Well-being and Contraceptive Side Effects

Thirty-one percent (n=180) of contraceptive users reported experiencing a health problem related to their contraceptive use. Not surprisingly, women who had experienced a health problem related to contraceptive use felt less "vitality" than did women who had not had a problem associated with contraceptive use ($t=2.78$, $p < 0.01$, data not shown). However, experiencing contraceptive side effects was not significantly associated with any of the other psychological well-being factors.

## 6. Decision-making Processes

An important component of this study was assessing women's decision-making processes regarding reproductive control. We hypothesized that women who had more autonomy in making reproductive decisions would have higher levels of psychological well-being. This section discusses the strategies used by women in one aspect of reproductive decision-making, decisions about use of contraception. Differences between women living in urban and rural areas and women living in the two provinces are discussed. In addition, women's levels of psychological well-being are analyzed based on the dominant decision-making strategies used by women in rural and urban areas.

Tables 15 and 16 show the differences in the persons who participated in decision-making regarding contraceptive use by urban/rural residence and by province. In general, women in rural and urban areas as well as in both provinces decided on the use of contraceptives with their spouses. In addition, in urban and rural areas and in both provinces, contraceptive use was largely perceived as the domain of women. Contraceptive decisions initiated by husbands were rare. There were, however, some differences in contraceptive decision-making between urban and rural areas and between the two provinces**.**

### a. Differences in Contraceptive Decision-making Between Urban and Rural Areas

We asked women about how they made the decision to use their most recent contraceptive method. The two most common decision-making patterns were: (1) the woman decided and her husband subsequently agreed with her decision, and (2) the woman and her husband made a joint decision (Table 15). The latter pattern was most common among rural women, while urban women were most likely to have decided on a method themselves and then secured their husbands' agreement. Few women made the contraceptive decision without ever consulting their husband.

Few women said a provider was the major decision-maker in selecting the family planning method. Nor did many women obtain their most recent method from a safari, although women in rural areas were more likely to have chosen a method because it was offered by a family planning safari (where only one method is available).

**Table 15: Patterns of Contraceptive Decision-making Reported by Women (In Percent), by Urban/rural Residence, South Sumatra and Lampung, 1996.**

| Pattern of decision-making | Urban (n=331) | Rural (n=336) |
|---|---|---|
| Respondent and husband discussed and decided together | 20.8 | 48.6 |
| Respondent decided, husband agreed | 65.5 | 44.1 |
| Respondent decided, husband disagreed | 3.6 | 0.9 |
| Husband decided, respondent agreed | 5.1 | 3.0 |
| Respondent decided by herself | 2.1 | 0.3 |
| Husband decided, and respondent disagreed but was compelled to use it | 0.6 | 0.3 |
| Decision affected by health provider | 1.2 | 0.6 |
| Safari KB | 0.3 | 2.1 |
| Others (parents, neighbors) affected decision | 0.9 | - |

**b. Differences in Contraceptive Decision-making in South Sumatra and Lampung**

Contraceptive decision-making patterns differed somewhat between South Sumatra and Lampung (Table 16). The majority of women in South Sumatra (65 percent) said they decided on the method, and their husbands then agreed. Close to half of women (47 percent) in Lampung also reported this decision-making pattern. Many Lampung women (44 percent) also said their contraceptive decision was made jointly with their husband.

**Table 16: Contraceptive Decision-making Reported by Women (In Percent), by Province, 1996.**

| Pattern of decision-making | South Sumatra (n=298) | Lampung (n=369) |
|---|---|---|
| Respondent and husband discussed and decided together | 23.5 | 43.6 |
| Respondent decided, husband agreed | 64.8 | 46.9 |
| Respondent decided, husband disagreed | 2.3 | 2.2 |
| Husband decided, respondent agreed | 4.0 | 4.1 |
| Respondent decided by herself | 0.7 | 1.6 |
| Husband decided, and respondent disagreed but was compelled to use it | 0.7 | 0.3 |
| Decision affected by health provider | 1.0 | 0.8 |
| Safari KB | 2.7 | - |
| Others (parents, neighbors) affected decision | 0.3 | 0.6 |

### c. Men's Participation in Contraceptive Decision-making

Although Tables 15 and 16 suggest that most women discuss their contraceptive use with husbands, few women had ever asked their husband to use a contraceptive method. Approximately 86 percent of current users had never asked their husbands to use a family planning method. Of the 14 percent who had asked their husbands to use a method, a little more than half of the husbands (54.2 percent) had agreed to use a method. The rest of the husbands would not consider using contraceptives (data not shown).

When asked who should be responsible for reproductive control, only 4.5 percent of women thought that reproductive control is the responsibility of husbands. The majority said that reproductive control is the responsibility of the wife (31.5 percent) or the couple together (64.0 percent). Similarly when asked about their husband's opinion, only 3.4 percent of women said that their husbands think reproductive control is a husband's responsibility (data not shown).

### d. Decision-making Processes and Psychological Well-being

We conducted bivariate analyses to assess the relationship between contraceptive decision-making patterns and factors of psychological well-being. Table 17 presents the results of this analysis for rural women, and Table 18 presents the results for urban women. We measured contraceptive decision-making using the two most common patterns reported by women in this study: (1) the woman decided and then the husband agreed, or (2) the woman and her husband made a joint decision. T-tests were conducted to test the difference between mean scores of well-being.

**Table 17: Mean Scores of Psychological Well-being, by Pattern of Contraceptive Decision-**

**making, Rural Women in South Sumatra and Lampung, 1996.**

| Factor of psychological well-being | Woman decided, husband agreed (n=111) | | Joint decision (n=133) | | t-value |
|---|---|---|---|---|---|
| | Mean score | SD | Mean score | SD | |
| Personal stress (-) | 0.12 | 0.98 | 0.17 | 0.98 | -0.40 |
| Satisfaction in relationships | -0.07 | 0.93 | 0.02 | 0.90 | -0.72 |
| Satisfaction with family welfare* | -0.25 | 0.97 | -0.02 | 0.87 | 1.98 |
| Role stress (-) | 0.07 | 1.00 | -0.17 | 0.94 | 1.89 |
| Child care and domestic responsibilities (-)** | -0.18 | 1.10 | 0.23 | 0.78 | -3.28 |
| Ability to attend to economic/social needs** | 0.49 | 0.85 | 0.20 | 0.77 | 2.80 |
| Vitality** | 0.10 | 0.93 | -0.23 | 0.91 | 2.76 |
| Time for self and others | 0.02 | 0.84 | -0.16 | 0.71 | 1.83 |
| Shame (-)** | 0.22 | 0.69 | -0.19 | 1.08 | 3.63 |
| Reproductive control | -0.12 | 0.82 | 0.00 | 0.81 | -1.16 |

(-) after a factor indicates the score was transformed from negative to positive. * indicates significant at $p < 0.05$. ** indicates significant at $p<0.01$.

Among rural women, those who decided on a method prior to getting their husbands' agreement differed significantly from those who made joint decisions with their husbands on five of the ten factors of psychological well-being (Table 17). Women who made a contraceptive decision before seeking their husbands' agreement felt less satisfied with their family's welfare and more overwhelmed by child care and domestic responsibilities than those who made a joint decision with their husbands. However, women who made the decision and then got their husbands' agreement felt more able to attend to their economic and social needs, greater vitality, and less shame about their families and themselves than joint decision-makers.

Among urban women, the pattern of contraceptive decision-making was associated with only two factors of psychological well-being (Table 18). Compared to women who made the most recent contraceptive decision jointly with their husbands, women who made a contraceptive decision and then got their husbands' agreement felt a higher level of personal stress and greater shame about themselves and their families.

**Table 18: Mean Scores of Psychological Well-being, by Pattern of Contraceptive Decision-making, Urban Women in South Sumatra and Lampung, 1996.**

| Factors of psychological well-being | Woman decided, husband agreed (n=152) | | Joint decision (n=51) | | t-value |
|---|---|---|---|---|---|
| | Mean score | SD | Mean score | SD | |
| Personal stress (-)** | -0.24 | 1.04 | 0.20 | 0.90 | -2.76 |
| Satisfaction in relationships | 0.20 | 0.94 | 0.02 | 1.21 | 1.15 |
| Satisfaction with family welfare | 0.24 | 1.04 | 0.31 | 0.92 | -0.44 |
| Role stress (-) | 0.04 | 1.03 | -0.03 | 0.96 | 0.40 |
| Child and domestic responsibilities (-) | -0.04 | 1.03 | -0.07 | 1.01 | 0.20 |
| Ability to attend to economic/social needs | -0.41 | 1.04 | -0.33 | 1.21 | -0.46 |
| Vitality | 0.05 | 1.10 | 0.15 | 0.86 | -0.66 |
| Time for self and others | 0.20 | 1.20 | 0.14 | 0.91 | 0.32 |
| Shame (-)* | -0.07 | 0.99 | 0.28 | 0.86 | -2.29 |
| Reproductive control | 0.15 | 1.21 | -0.12 | 0.95 | 1.49 |

* indicates significant at $p < 0.05$. ** indicates significant at $p < 0.01$.
(-) after a factor indicates the score was transformed from negative to positive.

## 7. Summary of the Effect of Women's Contraceptive Use and Reproductive Decision-making Patterns on Their Psychological Well-being

While family planning was associated with some factors of women's psychological well-being, psychological well-being is complex and is affected by numerous other factors in women's lives. In considering the effect of family planning, it is important to remember that almost all the women had some experience with family planning; 85.9 percent of study participants had ever used family planning, and 74 percent were currently using some type of contraceptive method (mostly modern methods). It is also important to remember that most women who reported working lived in rural areas; thus there is probably a high degree of correlation between work status and urban/rural residence. Still, the information on the effect of contraceptive use and other characteristics of women on their psychological well-being is revealing. Using the data presented in Tables 9 through 18, Table 19 summarizes the groups of women with statistically significant differences for each factor of psychological well-being (the variables associated with each factor are explained in Table 8).

*Personal stress* tended to be higher among women living in urban (rather than rural) areas, women who did not earn income (as opposed to working), and among urban women who made the decision to use contraception before discussing it with their husbands (compared to women in

urban areas who discussed contraceptive use with their husbands first before deciding to use a method).

Contraceptive users and users of modern methods tended to have more *satisfaction in their relationships* with others (including their husbands) compared to non-users and women who used traditional methods. Perhaps the fear of pregnancy leads to less satisfaction among women in their relationships with others.

In terms of *satisfaction with family welfare*, satisfaction with their family's welfare was higher among women in urban areas compared to women in rural areas; women who did not work compared to those who did work; women who terminated an unintended pregnancy compared to those who continued an unintended pregnancy; and users of the injection compared to users of the IUD or implant. Again, some of these differences may be related to urban/rural residence differences, since most of the women in urban areas do not work. In addition, rural women who made a joint contraceptive decision with their husbands were more satisfied with their family welfare than rural women who made their own contraceptive decision and then got their husbands' agreement.

It is interesting to note that contraceptive users felt more *role stress* did non-users. The roles included in this factor are those of wife and mother. Perhaps women who use contraceptives worry that they are going against their traditional roles of wife and mother and their responsibility to produce children for their husbands. This might be particularly true in rural areas.

For the factor, *child care and domestic responsibilities*, users of modern methods felt less overwhelmed by their child care and domestic responsibilities than users of traditional methods. Rural women who made a contraceptive decision jointly with their husbands (as opposed to those who decided on contraceptive use before discussing it with their husbands) also felt less overwhelmed by child care and domestic duties.

Women's *ability to attend to economic/social needs* was also affected by contraceptive use and decision-making. Users of modern contraceptive methods felt better able to attend to their economic and social needs than users of traditional methods, as did users of the IUD or implant (compared to users of injectables). Women who worked, rural women, and women in rural areas who took the initiative to decide on contraceptive use before discussing it with their husbands also felt more able than their counterparts to take care of economic/social needs. Taking care of economic and social needs included things like having extra time to earn income and to be involved in community activities or other outside interests.

Women's *vitality* (having no health problems and feeling "free") was higher among urban than rural women, among rural users who took the initiative in contraceptive decision making compared to rural users who made joint decisions with their husbands and, not surprisingly, among women with two or fewer children (compared to users with more than two children). Working women felt less vitality than non-working women. Vitality was also higher among

contraceptive users who had not experienced a health problem that they associated with contraceptive use.

Women in urban areas and women who did not work felt that they had more *time for themselves and others* than did their counterparts in rural areas and those who worked.

In terms of *shame*, women who lived in extended families, women who were income earners, urban women who took the initiative in contraceptive decision-making, rural women who discussed contraceptive use with their husbands before making a decision and younger women tended to feel more ashamed than did their counterparts. Shame in this case meant that a woman felt bothered that her family was a burden to the extended family, or felt ashamed of her family's and of her own personal appearance.

Finally, women who felt more able to exert *reproductive control* were (not surprisingly) contraceptive users; urban women; women in extended families; and women who had two or fewer children.

**Table 19. Summary of Groups of Women with Statistically Significant Differences in Factors of Psychological Well-being, Sumatra and Lampung, 1996.**

| Factor of psychological well-being | Groups of women with significantly higher score on the factor |
|---|---|
| Personal stress (-) | • urban women<br>• non-working women<br>• urban women who decided on contraception & then husband agreed |
| Satisfaction in relationships | • users<br>• users of modern methods |
| Satisfaction with family welfare | • urban women<br>• non-working women<br>• women who terminated an unintended pregnancy<br>• injection users<br>• rural women who made contraceptive decision jointly with husband |
| Role stress (-) | • users |
| Child care and domestic responsibilities (-) | • users of modern methods<br>• rural women who made contraceptive decision jointly with husband |
| Ability to attend to economic/social needs | • users of modern methods<br>• IUD and implant users<br>• rural women<br>• women who worked<br>• rural women who decided on contraception & then husband agreed |
| Vitality | • urban women<br>• rural women who decided on contraception & then husband agreed<br>• women who had not experienced contraceptive side effect<br>• women with two or fewer children<br>• non-working women |
| Time for self and others | • urban women<br>• non-working women |
| Shame (-) | • women in extended families<br>• working women<br>• urban women who decided on contraception & then husband agreed<br>• rural women who made joint contraceptive decision with husband<br>• younger women |
| Reproductive control | • contraceptive users<br>• urban women<br>• women with two or fewer children<br>• women in extended families |

(-) after a factor indicates the score was was transformed from negative to positive.

## 8. Experiences with Contraceptive Methods and Services

### a. Health Problems Associated with Contraceptive Use

Among the women who were using contraception, 31 percent (n=180) said they had experienced a "major" health problem related to their contraceptive use. Table 20 presents the health problems women felt were related to contraceptive use, by contraceptive method. Among users of the pill, injectables, and implants, headache was the most commonly reported problem. Irregular bleeding was the most common health problem among IUD users.

**Table 20: Contraception-related Major Health Problems Reported by Contraceptive Users (In Percent), by Contraceptive Method, South Sumatra and Lampung, 1996.**

| Major health problem* | Method Used | | | |
|---|---|---|---|---|
| | Pills (n=51) | IUD (n=11) | Injection (n=76) | Implant (n=43) |
| Headache | 28.6 | 10.5 | 26.4 | 27.9 |
| Weight gain | 15.3 | 10.5 | 18.9 | 4.7 |
| Amenorrhea | 9.2 | 5.3 | 16.2 | 9.3 |
| Irregular bleeding | 7.1 | 21.1 | 12.2 | 8.1 |
| Fatigue | 9.2 | 10.5 | 4.1 | 7.0 |
| Weight loss | 9.2 | 10.5 | 4.7 | 12.8 |

* Women could list up to three health problems.

Women were also asked whether they had experienced any non-health problems related to using contraceptives (data not shown). Fifteen percent of users (88 women) said they had. The most common non-health problems mentioned by the women were feelings of discomfort (44.3 percent), unattractive appearance (25 percent), and diminished desire for sex (17 percent).

Women were asked what they did when they experienced health problems. Among the 180 women who reported experiencing health problems, 74 percent said they discussed their problems with others, especially their husbands (55 percent), health professionals (32 percent), and female friends (32 percent). A quarter of the women said that they did not discuss their health problems with anyone else. The majority of these women (81 percent) chose to keep their problems to themselves, while 10 percent chose to drop out of the program (discontinued contraceptive use).

### b. Satisfaction with Contraceptive Use and Husband's Support

Current users of contraception were asked to indicate their satisfaction with the methods they used, the perceived satisfaction of their husbands with the methods, and their satisfaction with the support they received from their husbands regarding contraceptive use. Two-thirds (69 percent) said they were satisfied with the method they were using. Only 7.9 percent of current users indicated that they were not satisfied with the methods they used. Most women (94.2 percent) reported that their husbands were satisfied with their contraceptive choices, and 23.1 percent said their husbands were somewhat satisfied. Just 2.7 percent of users said they were not satisfied with

their husbands' support for their contraceptive use.

### c. Satisfaction with Information Received on Contraceptive Methods

Contraceptive users were asked about their satisfaction with the amount of information they received when selecting their most recent contraceptive method. The majority said they were "satisfied" (42.2 percent) or "somewhat satisfied" (40.8 percent) (data not shown). Only 17 percent of women reported that they were dissatisfied with the amount of information they had received about their current contraceptive method.

Women were then asked if they had received enough information when they were selecting their most recent method. Table 21 shows the proportion of women who, when asked, said they did not receive enough information, by type of information.

**Table 21: Percentage of Women Who Said They Did Not Receive Enough Information When Selecting Their Most Recent Contraceptive Method, by Type of Information, South Sumatra and Lampung, 1996.**

| Type of information | South Sumatra | | | Lampung | | | |
|---|---|---|---|---|---|---|---|
| | Urban | Rural | | Urban | | Rural | |
| | Duku (n=114) | Tanjung Beringin (n=63) | Perangai (n=66) | Tanjung Karang Pusat (n=73) | Pantai Panjang (n=72) | Gunung Sugih (n=81) | Bandar Jaya (n=71) |
| How method works | 13.3 | 13.7 | 17.7 | 38.4 | 48.3 | 39.5 | 40.8 |
| Side effects | 18.5 | 12.7 | 15.2 | 38.4 | 48.3 | 49.4 | 31.0 |
| Effectiveness | 21.1 | 11.1 | 12.1 | 31.5 | 43.1 | 39.5 | 23.9 |
| Follow-up | 18.4 | 6.3 | 6.1 | 41.1 | 40.3 | 22.2 | 38.0 |
| What to do when problem encountered | 15.8 | 1.6 | 3.0 | 19.2 | 19.4 | 12.2 | 19.7 |
| Where to get method | 34.2 | 11.1 | 10.6 | 34.2 | 26.4 | 24.7 | 21.3 |

Although women generally reported that they received adequate information on their contraceptive method, women respondents from South Sumatra were more likely than women from Lampung to say they were satisfied with the information they received (or maybe they were less likely to complain). For all types of information, women in Lampung were more likely to

report that they did not receive enough information when selecting their most recent contraceptive method.

Women who were contraceptive users were also asked what additional information they would like to receive to help them make contraceptive decisions. Table 22 shows women's responses to this question, by the method used. (Each woman could give up to three responses.) Among users of all four most commonly used methods, there was a clear desire for more information on contraceptive side effects: over 40 percent of users of each method requested more information about side effects. A high proportion of women also said they would like to know more about how their method works.

**Table 22: Topics on Which Contraceptive Users Would like Additional Information (In Percent)*, by Method Used, South Sumatra and Lampung, 1996.**

| Topic | Pills (n=127) | IUD (n= 51) | Implant (n=117 ) | Injection (n=148) |
|---|---|---|---|---|
| Side effects | 46.1 | 45.1 | 41.0 | 48.9 |
| How contraceptive method works | 39.5 | 37.3 | 37.3 | 25.6 |
| Effectiveness of methods | 28.9 | 25.5 | 18.8 | 25.6 |
| Effects on menstruation cycle | 22.4 | 17.6 | 20.5 | 29.4 |
| Follow-up | 23.7 | 25.5 | 18.8 | 22.8 |
| What to do when problems encountered | 19.7 | 17.6 | 24.8 | 21.7 |
| Where to get contraceptives | 12.5 | 3.9 | 6.0 | 11.7 |
| Price of contraceptives | 17.1 | 21.6 | 17.9 | 17.2 |

*Respondents could give up to three responses.

### d. Quality of Services

When asked about problems with regard to the quality of the family planning services women had most recently received, women were hesitant to complain. Table 23 summarizes the problems cited by women at the site where they most recently received family planning services, by study site. Limited clinic hours and distance from home were two problems commonly encountered by respondents. Although the percent of respondents complaining about the quality of providers was small, women living in the cities tended to perceive providers more negatively than did those in rural areas.

**Table 23: Problems Reported by Women Receiving Family Planning Services, by Study Site. South Sumatra and Lampung, 1996.**

| Type of problem | South Sumatra | | | Lampung | | | |
|---|---|---|---|---|---|---|---|
| | Urban | Rural | | Urban | | Rural | |
| | Duku (n=105) | Tanjung Beringin (n=34) | Perangai (n=31) | Tanjung Karang Pusat (n=28) | Pantai Panjang (n=41) | Gunung Sugih (n=37) | Bandar Jaya (n=23) |
| Place/instruments dirty | 7.6 | 8.8 | 6.5 | - | 4.2 | 5.4 | 4.3 |
| Waiting time too long | 21.9 | 20.6 | 25.8 | 21.4 | 34.1 | 16.2 | 8.7 |
| Rarely open for services | 11.4 | 8.8 | 25.8 | 10.7 | 24.4 | 16.2 | 13.0 |
| Limited hours | 52.4 | 35.3 | 45.2 | 35.7 | 39.0 | 51.4 | 34.8 |
| Too distant from home | 61.0 | 29.4 | 45.2 | 35.7 | 36.6 | 51.4 | 39.1 |
| Limited choice of methods | 61.0 | 2.9 | 6.5 | 7.1 | 26.8 | 16.2 | 13.0 |
| Quality of contraceptives | 20.0 | 5.9 | 0.0 | 3.5 | 7.3 | 5.4 | 0.0 |
| Expensive | 12.4 | 41.2 | 19.4 | 17.9 | 12.2 | 8.1 | 8.7 |
| Unfriendly providers | 23.8 | 11.8 | 22.6 | 28.6 | 12.2 | 2.7 | 4.3 |

Table 24 summarizes the problems with family planning services reported by women at the source they used most recently, by source of service (for the most commonly used sources of family planning). Long distance from home and limited hours were the most common complaints at most sites. Service from the *posyandu*[2] received the highest percentage of complaints. One-third to one-half the women complained that the posyandu was rarely open for services, had limited hours, offered a limited choice of methods, and had unfriendly providers. In fact, while fewer than 19 percent of women complained of unfriendly service at all other sites, 33 percent of women said the posyandu had unfriendly providers. Private midwives received the fewest complaints.

[2] Health and family planning integrated service post.

**Table 24: Problems with Family Planning Services Reported by Women (In Percent), by Source of Service. South Sumatra and Lampung, 1996.**

| Type of problem | *Puskesmas* (n=98) | Hospital (n=34) | Physicians (n=44) | *Posyandu* (n=18) | Private Midwives (n=80) | Safari (n=16) |
|---|---|---|---|---|---|---|
| Place/instruments dirty | 11.2 | 5.9 | - | 5.6 | 5.0 | - |
| Waiting time too long | 18.4 | 23.5 | 34.1 | 22.2 | 17.5 | 25.0 |
| Rarely open for services | 9.2 | 2.9 | 6.8 | 50.0 | 12.5 | 56.3 |
| Limited working hours | 56.1 | 47.1 | 43.2 | 55.6 | 25.0 | 50.0 |
| Distance too far from home | 45.9 | 61.8 | 52.3 | 16.7 | 50.0 | 31.3 |
| Limited choice of methods | 12.2 | 14.7 | 6.8 | 38.9 | 18.8 | 6.3 |
| Quality of contraceptives | 8.2 | 5.9 | 2.3 | 11.1 | 10.0 | 0.0 |
| Expensive | 15.3 | 26.5 | 29.5 | 11.1 | 21.3 | 18.8 |
| Unfriendly providers | 18.4 | 17.6 | 9.1 | 33.3 | 18.8 | 12.5 |
| Service needed not avail-able | 11.2 | 5.9 | 2.3 | 22.2 | 11.3 | 0.0 |

## 9. Women's Perceptions of the Effect of Family Planning on Their Lives

When we asked ever-users of modern contraception what their lives would be like if they *had not* used family planning, the majority indicated that things would be "worse" regarding: the general condition of their family (90 percent); the family economy (87 percent); their children's education (87 percent); their own health (77 percent); and their relationship with their husband (68 percent (data not shown). This pattern of responses was similar across users of different types of contraception.

We asked women who had never used modern contraception how their lives would have been different if they *had* used family planning. In general, women thought their lives would have been "the same" if they had used family planning. In the five aspects of life about which we asked, about two-thirds of women said their lives would not have been any different -- general family condition (61 percent), family economy (60 percent), children's education (60 percent), own health (63 percent), and relationship with husband (61 percent). Fewer than one-quarter of women (17-23 percent) thought their lives would have been better in these aspects (data not shown).

### 10. Reasons for Not Using Contraception

Among women who were not using family planning (n=199), the six most common reasons for non-use cited by respondents were: desire to have a child (36 percent), health problems (18.7 percent), lack of knowledge about contraceptive methods (17.8 percent), side effects (17.8 percent), husband prohibited use (13.1 percent), and difficulty getting pregnant/infertility (13.1 percent) (data not shown)[3]. It interesting to note that 22.4 percent of the respondents indicated that they relinquished their hope (*pasrah*), which is rather difficult to interpret. When a woman says that she is *pasrah* it may suggest that she feels that her life is not within her control, and, therefore, she needs external power to help her fulfill her wishes.

## C. In-depth Interviews with Women

In-depth interviews were conducted as part of this study to obtain more detailed information from women about their perceptions of the relationships among reproductive decision-making, use of contraception, and their psychological well-being. The information reported in this section relates, in the women's own words, their experiences with contraceptive use and the subsequent effects on their lives.

In the in-depth interviews, women were asked about their reasons for using or not using family planning and the role of significant others in the decision-making process. They were asked about their feelings regarding the decision to use family planning and the positive and negative effects using family planning had on their lives. Finally, women were asked about their lives in general and their expectations for their children.

### 1. The Legal, Cultural, and Religious Context of Family Planning and Husband-Wife Relations in Indonesia

The findings of the in-depth interviews must be put in the context of family planning use and the relationship between husbands and wives in Indonesia. Both have a legal and a cultural-religious basis for women.

### a. The Law

The pervasiveness of the family planning program in Indonesia has been widely documented, as has its "success" in reducing the fertility rate around the country. The year 1968 marked the start of the nationwide family planning movement. The first Five Year Development Plan (PELITA I), which started in 1969/70, supported a host of measures designed to lower fertility by as much as 50 percent by the year 1990 (BKKBN, 1995).
In 1992 the government passed Law No. 10/1992 on population and family welfare which

[3] Respondents could cite up to three responses.

stipulated that practicing family planning is a national duty. One woman in this study clearly indicated that the legal context of family planning is understood by the people:

> First, using IUD has been regulated by the law, and there is [what is called] the ABRI Manunggal[4]. I was told that it is best to use IUD. I myself want to participate in the program until my children are grown up. I discussed it with my husband. I said I wanted to use contraceptive, and he said that I could do what I wanted -- he endorsed my decision. *(Yang pertama, pakai spiral itu, kan ada Undang-Undang, ada ABRI Manunggal gitu. Terus dibilangin enak pasang spiral aja. Saya sendiri memang niat, niat mau ikut KB dululah biar anak besar. Saya musyawaroh dengan suami, bilang mau KB. Dia bilang ya situlah kalau mau, pokoknya dia merestui)* (LR-4).

Another woman noted that health and other social welfare policies will cover no more than two children per couple:

> I do not want to have another baby since only two children are covered by the social benefits in [my husband's] office... I am afraid that I will not be able to afford the cost of another child in the hospital *(Saya tidak mau punya anak lagi soalnya kantor kan cuma tiga yang ditanggung. Jadi saya takut melahirkan lagi..takut tidak bisa membiayai rumah sakit)* (SSU-2).

**b. Religion, Culture, and Gender Norms**

In Islam and in most Indonesian cultures, the man is considered the economic head of the household; wives are expected to obey their husbands and to look after their needs and take care of the home. Gender norms strongly influence the roles women and men play. Men's main roles are outside the household, while women's are inside the household taking care of the family.

In the past, Indonesia's family planning policy was challenged by religious groups, especially by Moslems and Catholics. In response to governmental lobbying and persuasion, the family planning program was finally supported by the leaders of all religious groups in the country (BKKBN, 1994). In practice, however, religious practices at the local level (including ideas regarding privacy for women) often hinder participation and use of certain contraceptives (Berninghausen and Kersten, 1992). A current study of family planning participation among Lampung Pepadun women, for example, indicates that the use of contraception is often perceived as against the teaching of the Holy Koran and as a threat to the masculinity of Pepadun men, who are

[4]A*BRI Manunggal*, literally translated means "the integration of the armed forces into the community." It is a government-sponsored program in which the armed forces help motivate community members to participate in the family planning program or KB, as well as other social, health, and religious programs.

considered the sole decision-makers in issues of family size (Hasyim, 1997).
Women in this study also noted the influence of religion and cultural norms on family planning use. Said one woman from rural Lampung:

> I am ashamed to use the IUD again. I feel shame..., when I have to take off my pants. Now it is different for me. I have been learning Koran and joined in evening prayers. I could not see how after all that I have been doing how I could use the IUD anymore. My friends said to me that I could not reveal my private parts after learning the Koran. *(Malu mau pake spiral lagi. Malu dengan diri sendiri. Harus buka-buka celana. Sekarang lain. Saya sudah ikut pengajian. Masa sudah ikut pengajian KBnya spiral. Orang-orang, teman-teman [bilang] masa sudah ikut pengajian punyanya diperlihatkan...)* (LR-4)

Gender norms that govern husbands' and wives' behavior have a powerful influence on women's contraceptive decision-making, requiring for example, that a woman seek her husband's permission to use contraception. MWT, a woman from urban Lampung had been wanting to join the family planning program for a long time. At one point she asked her husband's permission, but he did not agree. On the other hand, the wife of the RT (administrative leader of the community) urged her to begin family planning. After the birth of her fifth child, she tried using the pill without her husband's consent. When he found out, he didn't get angry. She continued using the pill for about five years, until a doctor told her that she was not allowed to use any method except the IUD or a condom anymore, since she had goiter. She was anxious about this because her husband didn't want to use the IUD or condoms, for no clear reason. She told the interviewer, "He only told me that he would not do it, for whatever reason." So, MWT stopped taking the pill, got pregnant, but then had a miscarriage after five months (LU-3).

**2. The Complexity of Contraceptive Decision-making**

**a. Perceptions about the Role of Family Planning**

Most women, and particularly those from rural areas, had a favorable impression of the role family planning could play in their lives. One woman from urban Lampung said she was using family planning to relieve herself of the burden of caring for small children, and to give her time for other activities:

I'd like to take a rest. I don't want to take care of small children anymore, I feel very tired. I'd like to have time to work for a living (LU-4).

A woman from rural Lampung said she was using family planning for both economic and health reasons. She had problems with pregnancy but also said family planning gave her more time and freedom to raise her children and interact with her husband (LR-1).

Another woman from rural Lampung said she used to be worried about getting pregnant and how she and her husband were going to support more children. She had experienced difficulties with

various methods of contraception. She got sterilized after her sixth child and reported finally feeling free, healthy, fresh, and able to work hard. Today, she says, she has a better relationship with her husband, she has more time for her children, and she is able to work hard in the field for a living. She is not fearful about her health any more. She hopes she doesn't have any more children and that she can raise her current children and let them "have their own future life." She also wishes that she could take care of her own parents. (LR-5).

A woman from Palembang in urban South Sumatra also appreciated being able to control her fertility. She said she now has a sense of security in her relationship with her husband, children and friends. In addition she said:

I am free to join organizational activities...Whenever they need me, I can always be available (SSU-1).

A woman from rural South Sumatra indicated that she used family planning to stop having children. Her first three were closely spaced. She said she uses family planning because her life is: ...too hectic already. I have to go to school to teach and hold my baby in my arm. So I work while taking care of my children. If the baby were still an infant, I could leave him at home. But when he learned to walk, he wanted to follow me. Therefore, I myself decided to join the family planning program. It is just too difficult [having many small children.]...I still have to do the laundry! But my husband sometimes helps me (SSR-3).

Another woman from rural South Sumatra described why she appreciated family planning:

Now I can put powder [make-up] on my face, while before I joined KB [the Family Planning Program] I felt sick most of the time, was losing weight, and was not healthy. I have had three children. Every time [during childbirth] I almost died (SSR-5).

Another woman from rural South Sumatra noted that she uses family planning:

...so that life isn't difficult. How could I work? In this village we could not go to the fields if we continue to give birth (SSR-6).

**b. Experiences with Contraceptive Methods and Support from Husbands**

While women generally supported the idea of family planning to space births and to limit the number of children they had, they had a range of contraceptive experiences and had used a variety of methods. Many women had switched from one contraceptive method to another (a pattern also noted in the survey) as a result of experiencing side effects, particularly from hormonal methods and the IUD.

Support from husbands, or the lack of such support, played a role in how women dealt with their contraceptive experiences. In the survey, as discussed previously, a large percentage of women reported that they had discussed family planning and contraceptive methods with their husbands. In the in-depth interviews, women said they felt most assured when their husbands helped, not only by openly discussing the alternatives, but also by actively taking part in family planning. Women were relieved when they felt able ("dared") to talk openly about the possibility of the husband actively taking part in family planning -- for example, by using condoms, the calendar method, or coitus interruptus. Women also felt relieved when they could talk to their husbands about problems they were having with contraceptive methods.

When asked why she and her husband decided to use the condom, an urban woman responded:

> My husband just went along. I just discussed it with him, and he agreed. He also liked the idea. He said, 'you are the woman who was told about the method with no negative effect. If there are problems, let's try the condom.' *(Saya masih tertarik yang pakai kondom tadi, pertama siapa yang mendorong?) Kalau bapaknya ini nurutan saja. (Bagaimana ibu memutuskan pakai kondom?) Kami mendiskusikannya dengan dia, dia mengizinkan, dio galak pula. Dia bilang: 'Sudah, kamu betino itulah yang mungkin mendengar yang mano yang idak raso ngganggu. Sudah, kalau banyak gangguan, cubo make kondom bae* (SSU-6).

When IB, a woman from urban Palembang, asked her husband whether she could use contraceptives to prevent pregnancy, he did not consent due to concern that contraception would have a negative effect on her health. Finally they made a deal to use the calender method:

I do not worry using the calendar system since he has promised we will not have another child until the baby grows up. He is not like other men. What's important for him is that he already has an offspring. *( Macem mana make kalender, ado rasa was-was apo mak mano?) Idak. Dio sudah berjanji, pokoknya kalu belum anak besar dio dak mungkin itu. Ada perjanjian. (Cak mano mengaturnyo?) Istilahnya kalu dio ado pengen tu na, tapi bukan di barang kiro, tapi digesek-geseke di paha bae macam itu. Macem itu sudah. Istilahnyo dio dak terlampau macam lanang-lanang lain, yang penting sudah dapat keturunan. (Yang milih kalender itu siapo?) Yang pertamo sayo. Ujinyo: 'ya sudah, yang penting satu janji...)* ( SSU-4).

Situations in which husbands and wives communicated about contraceptive use but the active participation of the husband was not discussed as an alternative were common. In these cases, husbands usually agreed that their wives could use family planning. There were also situations in which the decision to use contraception was based explicitly or implicitly on the husband's needs or interests. In other cases, when the wives experienced problems with many methods of contraception (or couldn't afford the cost) the couples resorted to the use of traditional methods or limited sexual intercourse in order not to get pregnant. Such practices, which require the active participation of husbands, sometimes caused problems in marital relationships.
From the interviews, it appears that many women perceived that their husbands didn't care one

way or the other about their wives' family planning use. For example, NRN, a woman from South Sumatra, used the injection after the birth of her third child. With the injection, she had a lot of physical problems, such as headaches and loss of appetite. The most troublesome problem, however, was her irregular periods. She experienced spotting every day for more than two weeks. It made her feel dirty, prevented her from praying in the mosque, and disturbed her relationship with her husband. Recently, a doctor had advised her to undergo sterilization, but she was not sure about taking that step. She said her husband was supportive of her choices, but he was very busy and had no time to take her to the clinic (SSU-2).

THR, a woman from Urban Lampung, also spoke of her experiences with contraceptive method-switching and complained of her husband's lack of understanding about the problems she had experienced using contraception. She had used the injection but experienced many problems, including bleeding, dizziness, dried and wrinkled skin, and her hair falling out. THR felt so unattractive that she discontinued the injection and had three more children. She then tried using the pill, but after four years of continuous physical problems, which included frequent headaches, irritability, and loss of desire for sex, her husband complained:

Your husband comes and you are just like *gedebok pisang* [as cold and passive as a banana tree]" (LU-5).

Another woman from Lampung, YUSN, also experienced unpleasant contraceptive side effects and found no sympathy from her husband. After the birth of her fourth child, she began to think seriously about using family planning, but she was afraid to discuss it with her husband. She tried the pill but experienced many physical problems. Her husband complained:

What is it! Your breasts are flattened, empty! (LU-6).

SRH, also from Lampung had the opportunity to get a free contraceptive injection during a Safari KB. She did not use the injection for long because she experienced physical problem. Then she switched to the pill. Since she started using the pill, she had been able to work harder and had time to earn additional income at a warehouse near their residence. But her husband was jealous because she met other men at work. He began to come home late and had an affair with another woman. So SRH stopped working, even though her income had helped the family economy. Her husband was a manual laborer at a seaport, where the work was sporadic and the wages were low (LU-4).

### 3. Summary of the In-depth Interviews

The in-depth interviews suggest that in Indonesia, contraceptive decision-making is strongly influenced by legal, cultural and religious norms. The women interviewed were aware of the legal and cultural climate that strongly encourages contraceptive use. Most women expressed

positive opinions about family planning in general, pointing in particular to the fact that having fewer children relieved their workload as well as the family's financial burdens.

However, using contraception was clearly not an easy matter for the women interviewed. Almost all had stopped using contraception or switched methods at some point. Almost all of the women had experienced problems with contraceptive use, and many described very unpleasant, even debilitating, experiences dealing with contraceptive side effects. Some women had difficulty using contraception but were unable to switch methods for financial reasons.

Overwhelmingly, the women interviewed made their contraceptive decisions within the framework of the interest of others, particularly their husbands. Their husbands' concerns and interests affected the types of methods they used and their decisions to switch methods or stop using contraception. The primacy of husbands' interests has made it difficult for women to discuss their own wishes and expectations. Many women felt it was their responsibility to quietly endure all the consequences of contraceptive use and not disturb their relationships with their husbands.

## IV. DISCUSSION AND RECOMMENDATIONS

### A. The Context of Reproductive Decision-making and Contraceptive Use

This study has shown that contraceptive decision-making among women from South Sumatra and Lampung is complex and must be examined within the prevailing cultural, legal and religious context. The quantitative data indicate that women initiated the decision to join the family planning program and use contraceptives. The in-depth interviews, however, revealed that women were not in as strong a position as the quantitative data suggested**.** Women felt caught between their legal, religious and culturally prescribed role as submissive partners to their husbands, and their personal needs for physical safety and their own and their family's welfare. Women described a range of benefits of family planning, including less stress and worry about family matters, more time with children and husbands, more time for work and community activities, and better health. It was clear that having children was perceived as a woman's duty to her husband (according to Islamic religious law) and, not surprisingly, that family planning was considered a woman's matter.

### B. Contraceptive Use

When it comes to the control of fertility, many women said they found it difficult to talk to their husbands. Perhaps as a result, most women took the lead in making contraceptive decisions, as long as the method they chose did not interfere with the sexual pleasure of their husbands. For example, they commented that their husband might feel the IUD during intercourse, find bleeding due to pill use disagreeable, or dislike changes in appearance due to contraceptive use (such as weight loss or decrease in breast size). Most importantly, a woman's contraceptive decisions had to be compatible with her husband's desired family size. Women often denied their own needs and interests to comply with their husbands' wishes. This often meant enduring dissatisfaction and

unpleasant experiences regarding the contraceptive method used. Some women --and couples -- resorted to limiting sexual contact in order not to get pregnant, a situation that often resulted in tension in the marital relationship. In the end, however, being able to space and limit births seemed to be a positive outcome for women, worthy of the hardships or inconveniences they suffered.

### C. Women's Psychological Well-being

The effect of family planning use and reproductive decision-making on women's psychological well-being was complex and varied by other circumstances in women's lives in addition to family planning. This study examined ten factors of psychological well-being that women (and men) indicated during focus group discussions were important to their lives. Those factors ranged from reproductive control and role stress to family welfare and relationships. In analysis of each factor, there was at least one statistically significant difference among the various groups compared for each factor.

#### 1. Reproductive Control

Women who feel more able to exert *reproductive control*, not surprisingly, were contraceptive users, users living in urban areas (who most likely have better access to contraceptive services), users who live in extended families, urban women who take the initiative in contraceptive decision-making, and users who have two or fewer children.

#### 2. Family Welfare and Opportunities for Economic and Social Activities

In terms of *satisfaction with family welfare*, contraceptive users in urban areas, users who were homemakers, and those who had terminated an unintended pregnancy (compared to those who continued an unintended pregnancy) were more likely to feel satisfied with their family's welfare.

Women's *opportunities to attend to economic/social needs* were also affected by contraceptive use and decision-making. Users of modern contraceptive methods, especially those who used the IUD or the implant, users who worked, and users in rural areas who took the initiative to decide on contraceptive use before discussing it with their husbands felt better able than their counterparts to attend to their economic and social needs. This difference appears to be primarily related to urban versus rural residence, since most of the women in urban areas did not work.

#### 3. Role Stress

Two factors were related to women's roles and the time they have to devote to them. It is interesting to note that contraceptive users felt more *role stress* than did non-users. The roles included in this factor were those of wife and mother. Perhaps women who use contraceptives worried that they were going against their traditional roles of wife and mother and their responsibility to produce children for their husbands. This might be particularly true in rural areas. For the

factor, *child care and domestic responsibilities*, rural women who had discussed contraceptive use with husbands (as opposed to those who had taken the initiative to decide on contraceptive use before discussing it with their husbands) felt less overwhelmed by child care and domestic duties. This factor also reflected lack of understanding from husbands and associated marital problems. Perhaps these women felt comfortable discussing contraceptive use with their husbands and felt that their husbands would listen to them rather than dismissing family planning as simply a woman's issue.

**4. Relationships**

Contraceptive users and users of modern methods tended to have more *satisfaction in their relationships* with others (including their husbands) compared to non-users and women who used traditional methods. Perhaps the fear of pregnancy led to less satisfaction among women in their relationships with others. Users in urban areas and users who did not work felt they had more *time for themselves and others* than did their counterparts in rural areas and those who worked.

**5. Personal Well-being**

Four factors of psychological well-being measured aspects of women's personal well-being. *Personal stress* tended to be higher among contraceptive users living in urban areas, users who did not work, and urban users who took made a contraceptive decision before discussing it with their husbands (compared to urban women who discussed contraceptive use with their husbands first before deciding to use a method).

Users in urban areas, rural users who took the initiative in contraceptive decision-making, users who had two or fewer children, and, not surprisingly, users who had not experienced a health problem associated with contraceptive use felt higher levels of "vitality" (no health problems and feeling "free").

Users who lived in extended families, users who worked, urban users who took the initiative in contraceptive decision-making, rural women who discussed contraceptive use with their husbands before making a decision, and younger women tended to feel higher levels of shame about themselves and their families than did their counterparts.

**D. The National Family Planning Program and Women's Well-being**

The National family planning program has targeted women for contraceptive use, and it has been very successful in increasing contraceptive prevalence and decreasing fertility in Indonesia. However, women have not always received sufficient information to enable them to choose the method best suited for their bodies and their personal circumstances. Women in this study experienced many side effects using contraceptive methods, but most persevered and frequently s-witched methods in order to avoid getting pregnant. Indonesian women could benefit from a strengthening of BKKBN's efforts to improve the quality of care at family planning service

delivery sites.

In the survey, on the factors of psychological well-being, women's perceptions of their health were worse if they had experienced a health problem related to contraceptive use. It is interesting to note that despite experiencing health problems they associated with contraceptive use, and despite not receiving sufficient information about contraceptive methods, most respondents expressed satisfaction with the family planning services they had last received. Perhaps this represents the Indonesian cultural tendency towards politeness and not expressing dissatisfaction. It is also important to consider the context of family planning in Indonesia. The strength of the National family planning program and the widespread acceptance of family planning and the small family norm might influence respondents to express societal beliefs about family planning more often than their own individual opinions. Unlike the survey, the FGDs and in-depth interviews revealed women's problems related to use of contraceptives. These problems were often aggravated by disagreements with or perceived lack of support from their spouses.

This is not to suggest that the results of this study do not reflect the reality of reproductive decision-making and its effect on women's psychological well-being. Rather, it suggests that the National family planning program, when designing future research or programs, should be aware that unfulfilled needs may not always be openly expressed. Small displays of dissatisfaction likely indicate deeper and broader concerns among women (and men) regarding family planning, contraceptive practice, and their own well-being.

This study provides the National family planning program with the important information that most women appreciate the benefits of joining family planning and that some aspects of women's psychological well-being are positively associated with using family planning to space and limit births. The following practical recommendations are proposed to improve the well-being of women and help women and men meet their reproductive intentions:

(1) The Program should challenge the myth that family planning and contraceptive use are only for women. Communication, education, and marketing efforts should depict men as active participants and encourage their participation in family planning. Men should be encouraged to support their wives' contraceptive choices, as well as use contraceptive themselves. Concerted effort should be made to identify the best venues and most appropriate language and approach to use in recruiting men as family planning participants. Greater male participation in family planning, both as methods users and supporters of their wives' family planning use, may improve family well-being by fostering greater gender equity regarding family planning use.

(2) It should be acknowledged that some men do actively participate in the program. Their experiences and expertise should be utilized to encourage more men to follow their example. For example, men already using family planning could be recruited as family planning promoters who focus on getting other men to take responsibility for couples' reproductive health.
(3) The family planning program should continue to improve efforts to provide women (and men) with better information on contraceptive options so that they have better experiences using

contraception. Providers need official encouragement and training in how to have more open and substantive communication about side effects and available options, and how to handle negative experiences. Providers should be prepared and eager to reduce clients' level of anxiety and uncertainty with regard to effectiveness and possible side effects of contraceptive use.

(4) To accompany better information and openness to communication on the part of providers, contraceptive services should be made more accessible (in terms of hours and location) and methods more affordable.

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**APPENDIX 1.**

## Local Coordinators and Data Collectors

**South Sumatra:**

Wahyu Ernaningsih (Local coordinator)
Siti Chairani
Kartini
Yusfirah
Desi Arisanti
Ita Simatupang
Elvera
Annalisa
Dwi Damayanti
Yusmaini
Anaknya bu Aan

FGDs coordinators and observers men:
Saut
Firman
Joni

**Lampung**

Sasmiati (Local coordinator)
Ari Nurweni
Trisnaningsih
Siti Badingah
Farida Hasjim
Adelina Hasjim
Arie Darmastuti
Ari Nurweni
Iis Sholihah
Ni Nyoman Wetty
Warnidah A.
Nurmalasari
Rohaida Aprilita
Emilizona
Djunaini

FGDs coordinators and observers men:
Mohamad Thoha
Buchori Asyik